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# BACKGROUND MATERIALS ON MEDICARE HOSPICE BENEFIT

## Including Description of Proposed Implementing Regulations

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Prepared by the Staff for the Use of the

COMMITTEE ON FINANCE
UNITED STATES SENATE

ROBERT J. DOLE, *Chairman*

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# I. BACKGROUND

## A. Introduction

Increasingly, hospice care has been recognized as an alternative way of caring for the terminally ill. The hospice concept generally emphasizes palliative care—medical relief from pain—rather than active care for the patients for whom there is no chance of a cure.

Hospice care is designed to help terminally ill patients remain free from pain and in the home environment as long as possible. By and large, patients are considered "terminal" when the prognosis for life expectancy is 6 months or less. Typically, care is delivered to such persons by an interdisciplinary team composed of a physician, nurses, and some combination of social worker, psychiatrist, psychologist, clergy, trained volunteers, and family members. Services are provided both to terminally ill persons and their families to help in adjusting to the patient's illness and death.

The origin of hospices can be traced to the Middle Ages when way stations were established by religious orders of knights to assist pilgrims journeying to and from the Holy Land. Hospices provided a place where people could stop to rest, eat, and refresh themselves, as well as receive medical and spiritual care. In later times, hospices came to mean a shelter for homeless people, the old, or incurably ill.

The modern hospice movement began in England with the founding in 1967 of St. Christopher's Hospice, a freestanding facility located in London. St. Christopher's later became the prototype for many similar institutions in the United States, among them the first United States hospice—Hospice, Inc., in New Haven, Connecticut (later renamed the Connecticut Hospice). A hospice program developed by the Royal Victoria Hospital in Montreal, Canada, has also gained wide recognition in the United States and has served as a model for many hospital-based hospice programs in this country.

While there is no standard definition of a hospice, the General Accounting Office (GAO) noted in a 1979 report on hospice care in the United States that there are four basic principles, which according to hospice advocates, distinguish hospices from the traditional health care system:

—The patient and his/her family, not just the patient, are considered the unit of care.

—A multidisciplinary team is used to assess the physical, psychological, and spiritual needs of the patient and family, develop an overall plan of care, and provide coordinated care.

—Pain and collateral symptoms associated with the terminal illness and its previous treatment are controlled, but no heroic efforts are made to cure the patient.

—Bereavement followup is provided to help the family to cope with their emotional suffering.

While the services provided by hospices may vary from one program to another, there are certain services which are provided in most hospice programs. GAO found the following services to be the most commonly available: home health care, including nursing care and home health aide services; pain control through medication; physical therapy; homemaker services; meal preparation in the home; and bereavement followup.

Hospice care is delivered through a variety of program models including the freestanding hospice, with or without direct affiliation to a hospital; the hospice unit within a hospital; the hospice team within a hospital; the hospice unit in a skilled nursing facility; and the so-called "hospice without walls" providing home care exclusively, most often through home health agencies and visiting nurse associations. There are an estimated 1,145 hospice programs in 50 States and the District of Columbia.

Legislation to cover hospice care under Part A of Medicare was contained in the Tax Equity and Fiscal Responsibility Act of 1982, signed into law on September 3, 1982, as Public Law 97-248. The Medicare program, authorized under title XVIII of the Social Security Act, is a Federal health insurance program for the aged and certain disabled. Medicare consists of two parts: the hospital insurance or Part A program covers inpatient hospital services, post-hospital skilled nursing facility services, and home health services. Medicare's supplementary medical insurance or Part B program covers physicians' services and certain other services such as outpatient hospital care.

Prior to the hospice legislation enacted under Public Law 97-248, Medicare did not recognize hospices as a separate category of provider eligible for reimbursement under the program, although some hospices were participating in the program within existing provider classifications (e.g., as a hospital, skilled nursing facility, or home health agency). As such, these organizations received limited reimbursement for certain of the services they provided. In addition, certain other hospice services, such as outpatient drugs that can be self-administered or services which might be considered custodial care, were not reimbursed under Medicare even if provided by a certified provider.

### B. Summary of Research and Demonstration Projects

Hospice care has been a subject of Federal study since 1973 when the National Cancer Institute funded a project to develop a national demonstration center for home care of the terminally ill and their families. Since then, several other studies and projects have been undertaken. In addition, the Joint Commission on Accreditation of Hospitals (JCAH) has been involved in a project to develop quality standards and a model accreditation program for hospice services. Major projects and studies undertaken since 1973 include the following:

## 1. Federal Efforts

### NATIONAL CANCER INSTITUTE

The National Cancer Institute (NCI) first funded hospice programs in 1973 when it made an award to Hospice, Inc. of New Haven, Connecticut, the first hospice in the Nation. The 3-year NCI contract (which expired in September 1977) was for the purposes of developing a national demonstration center for home care of the terminally ill and their families. During the contract period, Hospice, Inc., provided home care exclusively (it now operates an inpatient facility as well) with all patients receiving treatment and services without charge.

During fiscal year 1977 and fiscal year 1978, NCI awarded three additional demonstration projects totaling $4.9 million for a 3-year period. The funds were awarded to Hillhaven Hospice (Tucson, Arizona), Riverside Hospice (Boonton, New Jersey), and Kaiser-Permanent (Norwalk, California) and were intended to examine hospice care in facilities that operate relatively large home care programs and small inpatient facilities.

### THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE (HEW) SECRETARY'S TASK FORCE ON HOSPICE

At the request of then-HEW Secretary Califano, a Hospice Task Force was formed within the Department of Health, Education, and Welfare in 1978 to examine the status of the hospice movement in the United States, the effect of current Government policies, statutes, and regulations on hospices, and the appropriate role which the Federal Government might play in hospice development. The Task Force report was published in December 1978. The Task Force concluded that "the hospice movement as a concept for caring for the terminally ill and their families is a viable concept and one which holds out a means of providing more humane care for Americans dying of terminal illness while possibly reducing costs. . . . As such it is the proper subject of Federal support." The Task Force did not, however, recommend a specific form of support or role for the Federal Government, although several options were explored.

### ADMINISTRATION ON AGING (AOA)

Beginning in 1979, AOA made grants to several hospice demonstration projects. The programs involved the Hospice St. John in Wilkes-Barre, Pennsylvania; the University of Arizona, Tucson; the Hospice of the Valley, Phoenix, Arizona; the Hospice of Santa Barbara, California; and the Hospices of Seattle and Spokane, Washington. The projects examined how hospice services fit into the traditional system of care for the aged. The research covered a broad range of subjects, including the kind of buildings necessary for hospice services; demonstration of hospice programs; a comparison of different ways of organizing hospice programs; and the impact of different organizations on the quality and cost of hospice care. Reports on these projects were issued in 1982 and early 1983. Among other things, these studies found that a coordinated program of

health care for the terminally ill could be provided, primarily in the person's own home, as a viable alternative to other traditional health care programs; hospice care can reduce or avoid the crises that typically lead to institutionalization; different hospice program types can provide high quality effective care; and volunteers can play an important role in hospice care (according to Hospice St. John, the support from volunteers was often the deciding factor on whether a patient could be cared for at home rather than be returned to an institution).

#### GENERAL ACCOUNTING OFFICE (GAO)

In 1979, the GAO published a report to Congress entitled "Hospice Care—A Growing Concept in the United States" (HRD 79-50). The report examined the number, location, and characteristics of hospices; the characteristics of their patients; State licensing and health planning requirements; and operating costs and sources of funds. The report also looked at the extent to which hospice services are presently covered under Federal health programs and the changes needed if hospice services were to be added to programs such as Medicare and Medicaid.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION (HCFA) DEMONSTRATION PROJECTS

HCFA announced in October 1978 that it would fund demonstration and evaluation projects on providing care to terminally ill persons. For the purposes of these projects, HCFA waived program restrictions on payment under Medicare and Medicaid for custodial care at home, for bereavement counseling and other supportive services to the family, and for pain controlling drugs used at home. Since October 1980, HHS has been paying for all hospice care provided to terminally ill Medicare/Medicaid patients by 26 hospice organizations selected to participate in the 2-year demonstration projects. Outcomes of these projects are to be published at the end of September 1983. Certain preliminary findings from these projects are discussed in the data section of this report.

### 2. Non-Federal Efforts

#### JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (JCAH)

Early in 1981, JCAH began an 18-month project to develop quality standards and a model accreditation program for hospice services. A description of the activities of this project follows this section.

## II. DATA ON HOSPICES

### A. Joint Commission on Accreditation of Hospitals (JCAH) Survey

The Joint Commission on Accreditation of Hospitals (JCAH) was awarded a grant in 1981 by the W. K. Kellogg Foundation to: (1) determine the characteristics of hospice care in the United States; (2) assess the need for voluntary hospice accreditation; and (3) develop hospice standards. JCAH has established standards for the operation of hospitals and other health-related facilities and services and conducts voluntary survey and accreditation programs to determine whether facilities meet these standards of operation.

Through a variety of surveys, JCAH has collected information on the number, location, and characteristics of hospice programs in the country and has developed standards for their accreditation. At the present time, JCAH expects to publish two documents in November 1988: (1) a hospice standards manual, and (2) a self-assessment and survey guide for the application of these standards. JCAH anticipates that accreditation of hospice programs according to these standards will be available beginning in January 1984.

The JCAH survey has identified six major hospice provider types:

(1) The acute care hospital that has a hospice unit, identified hospice beds, or that identifies hospice patients on any ward and addresses their needs by a "floating team" (the scattered bed approach) and that provides home care either by a hospital-based home health agency or most likely through an informal verbal agreement with a community-based home health agency.

(2) A community home health agency, most often a visiting nurse association, whose staff is often divided into teams to provide hospice care to individual hospice patients. The program usually has informal, verbal arrangements for patient contact when the patient is admitted to a hospital. These arrangements are usually with 1 to 3 hospitals in programs east of the Mississippi and with 3 to 7 hospitals west of the Mississippi.

(3) An independent hospice program which is not owned by any other health care institution or agency. These programs are usually licensed and receive reimbursement as home health agencies but serve hospice patients only. The arrangements for hospice inpatient care are the same as indicated above for home health agencies/visiting nurse associations.

(4) A long-term care facility, most often a skilled nursing facility, which has 1 to 4 identified hospice beds and may or may not have identified hospice inpatient staff, but usually provides



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general home care services through a contract with a home care agency.

(5) Volunteer hospices with an average of 1.5 full-time equivalent paid staff and a number of volunteer staff that can include physicians, registered nurses, social workers, and others. Volunteer hospices usually provide care informally in conjunction with existing home health agencies and hospitals. In the East, the number of volunteers in these hospices averages about 35-40; in the West, volunteer programs can have 75-100 or more trained volunteers.

(6) The case management model where a hospice works with an existing home health agency and/or hospital by providing those services that are hospice specific. These are most often bereavement counseling, spiritual services, social services, and volunteer services. The hospice in this instance is supplemental and is not primarily responsible for the care of the patient.

Preliminary data collected by JCAH indicate that there are approximately 1,145 hospice programs in the United States. JCAH points out, however, that this statistic can be misleading, (1) since only a limited number of States have any kind of licensing requirements for hospices; and (2) in replying to a survey questionnaire, providers can indicate that they are a hospice program or provide hospice care, even if they would not meet certain standards for providing care.

In a preliminary analysis of data collected, JCAH has found that 499 programs considered themselves to be full providers of services; that is, they provided both home care and inpatient services directly or under arrangement with others. For another 567 hospices, JCAH has not been able to determine their provider status at this time. Seventy-nine hospices indicated that they were in the planning stages of development.

JCAH has also found that classifying hospices by ownership provides a useful tool by which to summarize differences in the services provided by various hospices. The following Table 1 indicates that most hospices are either independently-owned (not owned by any other institution or agency), hospital-owned, or home health agency-owned. Table 2 details this data by State.

TABLE 1.—JCAH SURVEY OF HOSPICE PROGRAMS: ESTIMATED TOTAL NUMBER OF HOSPICE PROGRAMS, BY PROVIDER STATUS AND OWNERSHIP, MARCH 1983

| | |
|---|---|
| Provider status: | |
| Self-reported as full providers of home care and inpatient services | 499 |
| Unknown provider status | 567 |
| In planning stages | 79 |
| Estimated number of hospice programs | 1,145 |
| Hospice program ownership: | |
| Independent | 470 |
| Hospital | 437 |
| Home health agency | 210 |
| Long-term care facility | 18 |
| County health department | 8 |
| Psychiatric facility | 2 |

Source: Unpublished JCAH data.

TABLE 2.—JCAH SURVEY OF HOSPICE PROGRAMS: ESTIMATED NUMBER OF HOSPICE PROGRAMS BY STATE, MARCH 1983

| State | Hospice program ownership | | | | | | | Provider status | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Independent | Hospital | Home health agency | Long-term care facility | County health department | Psychiatric facility | Total | Full provider of services (Home care and inpatient) | Unknown | In planning stages |
| Alabama | 6 | 8 | 10 | 1 | 1 | | 26 | 8 | 6 | 12 |
| Alaska | 2 | | | | | | 2 | 2 | | |
| Arizona | 6 | 1 | 2 | | | | 9 | 2 | 7 | |
| Arkansas | 3 | 1 | 1 | | | | 5 | 3 | 2 | |
| California | 58 | 56 | 36 | | | | 150 | 72 | 76 | 2 |
| Colorado | 15 | 6 | | | | | 21 | 15 | 4 | 2 |
| Connecticut | 10 | 9 | 12 | | | | 31 | 6 | 23 | 2 |
| Delaware | 1 | 2 | | | | | 3 | | 3 | |
| District of Columbia | 2 | | | | | | 2 | 2 | | |
| Florida | 16 | 9 | 1 | | | | 26 | 13 | 13 | |
| Georgia | 11 | 8 | 1 | 1 | | | 21 | 11 | 6 | 4 |
| Hawaii | 2 | 2 | | | | | 4 | 1 | 3 | |
| Idaho | 1 | 4 | | 2 | | | 7 | 1 | 6 | |
| Illinois | 16 | 35 | 12 | 5 | | | 68 | 44 | 11 | 13 |
| Indiana | 11 | 6 | | | | | 17 | 10 | 7 | |
| Iowa | 4 | 16 | 2 | | | | 22 | 5 | 16 | 1 |
| Kansas | 12 | | 4 | | | | 16 | 6 | 9 | 1 |
| Kentucky | 14 | 8 | 1 | | | | 23 | 8 | 14 | 1 |
| Louisiana | 4 | 5 | 1 | | | | 10 | | 5 | 5 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Maine | 15 | 5 | | | | | 20 | 15 | 4 | 1 |
| Maryland | 10 | 11 | 6 | 1 | | | 28 | 14 | 14 | |
| Massachusetts | 27 | 12 | 11 | 1 | | | 51 | 28 | 23 | |
| Michigan | 9 | 7 | 5 | | | | 21 | 9 | 11 | 1 |
| Minnesota | 6 | 20 | | | | | 26 | 15 | 9 | 2 |
| Mississippi | 1 | 3 | 2 | | | | 6 | 1 | 4 | 1 |
| Missouri | 10 | 9 | 5 | 1 | | | 25 | 13 | 9 | 3 |
| Montana | 12 | 3 | | | | | 15 | 5 | 10 | |
| Nebraska | 2 | 9 | 1 | 1 | | | 13 | 3 | 7 | 3 |
| Nevada | 1 | | 1 | | | | 2 | 1 | 1 | |
| New Hampshire | 12 | 2 | 6 | | | | 20 | 4 | 16 | |
| New Jersey | 7 | 23 | 7 | | 1 | | 38 | 19 | 19 | |
| New Mexico | 4 | 1 | 3 | | | | 8 | 5 | 3 | |
| New York | 7 | 24 | 3 | | | 1 | 35 | 17 | 15 | 3 |
| North Carolina | 25 | 6 | 3 | | 2 | 1 | 37 | 15 | 14 | 8 |
| North Dakota | 2 | 3 | | | | | 5 | 1 | 4 | |
| Ohio | 20 | 13 | 7 | | 1 | | 41 | 19 | 22 | |
| Oklahoma | 3 | 2 | | | | | 5 | 2 | 2 | 1 |
| Oregon | 10 | 11 | 3 | | 1 | | 25 | 4 | 21 | |
| Pennsylvania | 13 | 32 | 29 | 1 | | | 75 | 30 | 45 | |
| Rhode Island | 2 | 1 | 5 | | | | 8 | 1 | 7 | |
| South Carolina | 3 | 3 | | | | | 6 | 2 | 4 | |
| South Dakota | 2 | 1 | | | | | 3 | 1 | 2 | |
| Tennessee | 4 | 13 | 2 | | 1 | | 20 | 7 | 11 | 2 |
| Texas | 12 | 8 | 15 | | | | 35 | 14 | 16 | 5 |
| Utah | 5 | 1 | | | | | 6 | 3 | 3 | |

TABLE 2.—JCAH SURVEY OF HOSPICE PROGRAMS: ESTIMATED NUMBER OF HOSPICE PROGRAMS BY STATE, MARCH 1983—Continued

| State | Hospice program ownership | | | | | | | Provider status | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Independent | Hospital | Home health agency | Long-term care facility | County health department | Psychiatric facility | Total | Full provider of services (Home care and inpatient) | Unknown | In planning stages |
| Vermont | 5 | 3 | 7 | | | | 15 | 4 | 11 | |
| Virginia | 6 | 7 | 1 | 2 | | | 16 | 7 | 8 | 1 |
| Washington | 19 | 7 | 4 | 2 | | | 32 | 8 | 22 | 2 |
| West Virginia | 6 | 7 | | | | | 13 | 3 | 10 | |
| Wisconsin | 15 | 14 | 1 | | 1 | | 31 | 19 | 10 | 2 |
| Wyoming | 1 | | | | | | 1 | 1 | | |
| Total | 470 | 437 | 210 | 18 | 8 | 2 | 1,145 | 499 | 567 | 79 |

Source: Unpublished JCAH data.

## B. State Licensure and Certificate-of-Need Laws

According to a recent survey, States are beginning to apply their licensure laws and certificate-of-need laws to hospice programs. State certificate-of-need laws provide for the review and approval/disapproval of new institutional health services, major medical equipment, and capital expenditures exceeding certain dollar limits. As Table 3 indicates, 16 States and Puerto Rico cover hospice care programs under their licensure laws and 27 States and the District of Columbia and Puerto Rico cover hospice programs under their certificate-of-need laws.

TABLE 3.—STATE LICENSURE AND CERTIFICATE-OF-NEED LAWS COVERING HOSPICE PROGRAMS, MAY 1983

| | Licensure | Certificate-of-need |
|---|---|---|
| Alabama | No | Yes. |
| Alaska | No | Institutional. |
| Arizona | No | Institutional. |
| Arkansas | No | Yes. |
| California | No | No. |
| Colorado | No | No. |
| Connecticut | Yes | Institutional. |
| Delaware | Yes | Yes. |
| District of Columbia | No | Yes. |
| Florida | Yes | Yes. |
| Georgia | Yes | No. |
| Hawaii | Freestanding | Yes. |
| Idaho | No | No. |
| Illinois | No | No. |
| Indiana | Yes | Hospital. |
| Iowa | No | Institutional. |
| Kansas | No | No. |
| Kentucky | Yes | Yes. |
| Louisiana | No | No. |
| Maine | No | No. |
| Maryland | Freestanding | Yes. |
| Massachusetts | No | No. |
| Michigan | Yes | Yes. |
| Minnesota | No | Institutional. |
| Mississippi | No | No. |
| Missouri | No | Institutional. |
| Montana | Yes | Institutional. |
| Nebraska | No | No. |
| Nevada | Yes | Yes. |
| New Hampshire | No | Yes. |

TABLE 3.—STATE LICENSURE AND CERTIFICATE-OF-NEED LAWS COVERING HOSPICE PROGRAMS, MAY 1983—Continued

| | Licensure | Certificate-of-need |
|---|---|---|
| New Jersey | No | No. |
| New Mexico | Yes | No. |
| New York | No | No. |
| North Carolina | No | No. |
| North Dakota | No | No. |
| Ohio | No | Institutional. |
| Oklahoma | Inpatient | Institutional. |
| Oregon | No | No. |
| Pennsylvania | No | No. |
| Puerto Rico | Yes | Yes. |
| Rhode Island | No | No. |
| South Carolina | Yes | Institutional. |
| South Dakota | No | Institutional. |
| Tennessee | No | No. |
| Texas | No | No. |
| Utah | No | Yes. |
| Vermont | No | Yes. |
| Virginia | Yes | Yes. |
| Washington | Freestanding—inpatient | Freestanding—inpatient. |
| West Virginia | No | Yes. |
| Wisconsin | No | No. |
| Wyoming | No | No. |

Source: Home Health Line, May 30 and June 6, 1983.

Note: Terms such as "freestanding," "inpatient" and "institutional" indicate that laws apply only to hospice services in those settings.

### C. Preliminary Hospice Demonstration Patient Cost and Utilization Patterns

In 1979, the Health Care Financing Administration (HCFA) implemented a demonstration program to gather data on the costs, use, and quality of care provided by hospice organizations and to determine which care models best incorporate the hospice concept. In 1980, HCFA, in conjunction with the Robert Wood Johnson Foundation and the John A. Hartford Foundation, selected Brown University to conduct an in-depth, independent study of the hospice project. The ultimate objective of this study is to assess the cost-effectiveness of providing hospice care to terminally ill Medicare and Medicaid beneficiaries. A final report should be completed in September 1983 and will address the following additional questions: (1) What are the differential patterns of utilization and cost of caring for comparable terminally ill patients in hospices and

conventional care settings? (2) What is the likely impact of Medicare reimbursement on the organizational structure, staffing patterns, and costs of hospices? (3) What are the differences in the services which hospice and non-hospice patients receive? (4) What is the differential impact of hospice care on the quality of life of terminal patients and their families, as compared to conventional care?

The following three tables present preliminary data regarding patients' service utilization and costs in the hospice demonstration setting. The data were obtained by conducting a series of interviews with terminally-ill hospice patients and their families who entered the hospice demonstration program after August 1, 1981 and died by April 1982. The patient sample size for these preliminary tables consists of 307 hospice demonstration patients receiving care in 11 hospital-based hospices and 597 hospice demonstration patients receiving care in 14 home health agency-based hospices. Patients kept a log and recorded all health encounters during the hospice experience. Full time data collectors, trained and supervised by Brown University, visited the patients every two weeks and collected the log. This information was supplemented with data abstracted from the patients' hospice medical records and Medicare billings.

Table 4 presents preliminary data on average utilization of hospice services by patients in the demonstration program. For patients receiving care through a home health agency-based hospice, average length of stay in the program was 54.2 days, with these patients using an average of 7.6 days of inpatient care (14 percent of the total) and an average of 46.6 days of home care (86 percent of the total). For patients in hospital-based hospices, average length of stay in the program was 51.1 days, with these patients using an average of 18.9 days of inpatient care (37 percent of the total) and an average of 32.2 days of home care (63 percent of the total).

These preliminary data also indicate that home health agency-based hospice patients used an average of 45.6 home visits, while hospital-based hospice patients used an average of 25.3 home visits.

Table 5 shows estimated costs for various hospice services used to calculate estimated total hospice care costs per patient. Table 6 indicates that for patients receiving care through home health agency-based hospices, the estimated preliminary cost per patient was $4,026. For those receiving care through hospital-based hospices, the estimated preliminary cost per patient was $6,511.

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## TABLE 4.—AVERAGE UTILIZATION PER PATIENT BY TYPE OF HOSPICE

| Utilization | Hospice | |
|---|---|---|
| | HHA-based | Hospital-based |
| Patients | 597 | 307 |
| Average length of stay (days) | 54.2 | 51.1 |
| Inpatient | 7.6 | 18.9 |
| Home | 46.6 | 32.2 |
| Percentage distribution of stay | 100.0 | 100.0 |
| Inpatient | 14.0 | 37.0 |
| Home | 86.0 | 63.0 |
| Average number of home visits | 45.6 | 25.3 |
| Nursing | 18.5 | 8.7 |
| Home health aide/maker | 24.0 | 15.4 |
| Social services/therapy | 3.1 | 1.2 |

Source: Preliminary November 1982 National Hospice Sample Data on Demonstration Hospice Patients Only, through Summer 1982, HCFA, DHHS.

Note: Final NHS results could vary considerably from these preliminary estimates because both patients with very short stays (3 days and less) and those patients with long lengths of stay (over 180 days) are underrepresented in this preliminary sample.

## TABLE 5.—ESTIMATED COST PER SERVICE, BY TYPE OF SERVICE AND TYPE OF HOSPICE, 1981

| Type of service | Hospice | |
|---|---|---|
| | HHA-based | Hospital-based |
| Inpatient (per day) | [1] $203 | [2] $266 |
| Room and board (est. cost) | 118 | 221 |
| Ancillary (est. cost) | 85 | 45 |
| Estimated charge | 206 | 114 |
| Home care (per day) [3] | 53.28 | 46.07 |
| Drugs [3] | 5.50 | 5.50 |
| Other | 47.78 | 40.57 |
| Home care (per visit): [3] | | |
| Nurse | 60.00 | 73.00 |
| Home aide/maker | 38.00 | 39.00 |
| Social services/therapy | 66.00 | 59.00 |

[1] The room and board cost represents the fiscal year 1980 national average Medicare reimbursement for inpatient room and board inflated to fiscal year 1981 dollars=$118/day. The ancillary figures were derived by sampling 150 hospice patients' records, producing an average charge of $206/day for ancillaries. The ancillary cost estimate was derived by applying the ancillary cost to charge ratio from the hospital-based hospices to the ancillary charge data for the HHA-based hospices.

[2] Represents fiscal year 1981 average per diem inpatient costs for demonstration hospices from provisional first year cost reports, calculated with the extreme high cost facility omitted whose inpatient per diem was over three times the mean of the other facilities. Average ancillary charges per inpatient day were obtained from preliminary demonstration bill files from October 1980 through Apr. 1, 1982 for patients who died.

[3] Fiscal year 1981 average nursing, home health aide and therapy and social service costs per visit for demonstration hospices, from provisional first year demonstration cost reports.

Source: Preliminary NHS data on sample of NHS patients, HCFA, DHHS.

TABLE 6.—ESTIMATED (PRELIMINARY) COST PER PATIENT BY TYPE OF SERVICE AND TYPE OF HOSPICE, 1981

| Type of service | Hospice | | | | | |
|---|---|---|---|---|---|---|
| | HHA-based (597 patients) | | | Hospital-based (307 patients) | | |
| | Total | Days | Cost | Total | Days | Cost |
| Inpatient | $1,542.80 | 7.6 | $203.00 | $5,027.40 | 18.9 | $266.00 |
| Room and board | 896.80 | 7.6 | 118.00 | 4,176.90 | 18.9 | 221.00 |
| Ancillaries | 646.00 | 7.6 | 85.00 | 850.50 | 18.9 | 45.00 |
| Home care | 2,482.90 | 46.6 | 53.28 | 1,483.60 | 32.2 | 46.07 |
| Nursing (visits) | 1,110.00 | 18.5 | 60.00 | 635.10 | 8.7 | 73.00 |
| Home health/maker (visits) | 912.00 | 24.0 | 38.00 | 600.60 | 15.4 | 39.00 |
| Social service/therapy (visits) | 204.60 | 3.1 | 66.00 | 70.80 | 1.2 | 59.00 |
| Drugs/supplies | 256.30 | 46.6 | 5.50 | 177.10 | 32.2 | 5.50 |
| Total hospice | 4,025.70 | | | 6,511.00 | | |

Source: Preliminary NHS utilization data weighted by cost data from first year demonstration hospice cost reports and by average national Medicare inpatient rates, HCFA, DHHS.

Note: Final NHS results could vary considerably from these preliminary estimates because both patients with very short stays (3 days and less) and those patients with long lengths of stay (over 180 days) are underrepresented in this preliminary sample.

## III. LEGISLATIVE ACTION

### A. Chronology of Events

Since 1980, legislation has been considered to provide for coverage of hospice care under Medicare. In 1980, during the 96th Congress, H.R. 7744 was introduced by Representative Leon Panetta (D.-Calif.) to provide reimbursement under Part B of Medicare for hospice services to terminally ill persons. No action was taken on this legislation.

During the 97th Congress, H.R. 5180, S. 1958 were introduced to provide coverage for hospice care under Part A of Medicare. Lead sponsors of these companion bills were Representative Leon Panetta (D.-Calif.), et al. (H.R. 5180) and Senator Robert Dole (R.-Kan.), et al. (S. 1958). Hearings on hospice care were held by the House Ways and Means Committee and the Senate Aging Committee following the introduction of these bills. The legislation was similar to the hospice benefit ultimately included in the Medicare program as part of the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248. The following is a capsule summary of legislative events leading up to the inclusion of a hospice benefit in the Medicare program under Public Law 97-248. In addition, major legislative events resulting in an amendment of this benefit during the 98th Congress are detailed.

*96th Congress*

7/2/80—H.R. 7744 introduced by Representative Leon Panetta to provide coverage for hospice care under Part B of Medicare.

*97th Congress*

12/11/81—H.R. 5180 introduced by Representative Leon Panetta et al. to provide coverage for hospice care under Part A of Medicare; referred to the Committee on Ways and Means, and Energy and Commerce.

12/15/81—S. 1958 introduced by Senator Robert Dole et al. to provide coverage for hospice care under Part A of Medicare; referred to the Committee on Finance.

3/25/82—Hearing on H.R. 5180 held by Health Subcommittee of House Ways and Means Committee.

5/24/82—Hearing on hospice care held by Senate Special Committee on Aging.

7/15/82—House Ways and Means Committee made tentative decisions pursuant to directives contained in budget resolution regarding health programs; these tentative decisions included Medicare coverage for hospice services.

7/23/82—Senate passed H.R. 4961, the Tax Equity and Fiscal Responsibility Act of 1982, containing a floor amendment providing hospice care under Medicare.

7/28/82—H.R. 6878, which incorporated the tentative decisions made by the Ways and Means Committee regarding health programs, including Medicare coverage for hospice services, was introduced by Representatives Rostenkowski and Gradison.

8/19/82—Senate and House passed conference report on H.R. 4961, containing hospice care provisions.

9/03/82—President signed H.R. 4961 into law (P.L. 97-248).

*98th Congress*

6/20/83—House Ways and Means Committee reported H.R. 3021, Health Care for the Unemployed which, among other things, included an amendment to the hospice care cap. This amendment established a new cap of $6,500, indexed by changes in the medical care component of the Consumer Price Index. On August 3, House passed a clean bill H.R. 3521, Health Care for the Unemployed, which contained this amendment.

7/25/83—Senate Finance Committee reported S. 951, Health Services for the Unemployed, which, among other things, included an amendment to the hospice care cap. This amendment established a new cap of $6,500, indexed by changes in the medical care component of the Consumer Price Index.

8/01/83—H.R. 3677, a clean bill introduced by Representatives Leon Panetta (D., Calif.) and Willis Gradison (R., Ohio) on July 27, 1983 and embodying the hospice cap amendment included in H.R. 3021 (Health Care for the Unemployed), passed by House.

8/03/83—H.R. 3677 passed by Senate.

8/29/83—H.R. 3677 signed by President.

## B. Hospice Care Under Public Law 97-248 and H.R. 3677

### 1. Eligibility and Conditions of Coverage

For the period November 1, 1983 to October 1, 1986, Medicare Part A coverage is expanded to include hospice care services provided to terminally ill Medicare beneficiaries with a life expectancy of 6 months or less. A Medicare beneficiary may elect to receive hospice care in lieu of most other Medicare benefits for up to two periods of 90 days each, plus an additional period of 30 days (totaling 210 days). During the time a hospice election is in effect, the beneficiary will be deemed to have waived entitlement to: (1) hospice care provided by another hospice program (except when the hospice from which the individual elected to receive care makes arrangements with another hospice to provide services it does not offer directly); and (2) any Medicare services related to the treatment of the individual's terminal illness, or services equivalent to or duplicate of hospice care. However, the waiver does not apply to services provided by the beneficiary's attending physician if the attending physician is not employed directly by the hospice program. Further, the waiver only applies to those services provided by or under arrangements with the hospice.

After an individual makes a hospice election, he may revoke it; however, he will be deemed to have used benefits for the entire election period then in effect. Any time after revocation, he may execute a new election for a subsequent period if he is otherwise

entitled to hospice benefits. In addition, once each election period, the individual may change hospice programs.

For an individual to have payments made on his behalf for hospice care during the first 90-day election period, his attending physician and the medical director (or physician member of the interdisciplinary group) of the hospice providing the care must each certify not later than 2 days after hospice care is initiated that the individual is terminally ill. Attending physician is defined as the physician, who may be employed by a hospice program, whom the beneficiary electing hospice care identifies as having the most significant role in the determination and delivery of his medical care at the time election of hospice care is made. At the beginning of subsequent periods, the medical director or physician member of the interdisciplinary team must recertify that the individual is terminally ill. A beneficiary is considered terminally ill if there is a medical prognosis that his life expectancy is 6 months or less.

In addition to these certifications, a written plan must be established for the care to be provided an individual electing hospice care. This written plan must be established before care is actually provided and must be periodically reviewed by the individual's attending physician and by the medical director and the interdisciplinary group of the hospice.

2. Benefits

Hospice care benefits covered by Medicare include the following:

(1) Nursing care provided by or under the supervision of a registered professional nurse;

(2) Physical or occupational therapy, or speech-language pathology;

(3) Medical social services under the direction of a physician;

(4) Services of a home health aide who has successfully completed a training program approved by the Secretary, and homemaker services;

(5) Medical supplies (including drugs and biologicals) and the use of medical appliances;

(6) Physicians' services;

(7) Short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide hospice care; and

(8) Counseling, including dietary counseling, with respect to care of the terminally ill individual and adjustment to his death. Hospices must provide bereavement counseling, but such counseling will not be considered a reimbursable cost under the hospice benefit.

Nursing care and home health aide and homemaker services may be provided on a 24-hour continuous basis only during periods of crisis and only as necessary to maintain the terminally ill individual at home. The aggregate number of inpatient care days provided in any 12-month period to individuals electing a particular hospice program may not exceed 20 percent of the aggregate number of days of hospice coverage provided to these persons. In

addition, respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than 5 days. (Although respite care is not defined, it is generally considered to consist of temporary, short-term relief services provided in a facility or the patient's home, so that family members or those providing primary care in the home may have a few hours or days of rest from caring for the patient.) Counseling services, including nutritional and dietary counseling, will be covered, but may not be billed for as separate services.

Beneficiary copayments are required for outpatient drugs and respite care. Hospice programs are required to establish drug copayment schedules; beneficiary charges (not exceeding $5 per prescription) are to approximate five percent of the cost of the drug to the hospice program. For respite care, the coinsurance amount will be equal to five percent of the estimated payments to the hospice program for respite services, but not exceeding the applicable Medicare hospital deductible during the period of hospice election (as long as the hospice election is not broken by more than 14 days). No other cost sharing charges are permitted for hospice services provided during the period of a hospice election.

### 3. Requirements for Hospice Programs

Hospice programs will be eligible to participate in Medicare if they are either public agencies or private organizations primarily engaged in providing the hospice services described above and if they make such services available (as needed) on a 24-hour basis, in individuals' homes, on an outpatient basis, and on a short-term inpatient basis.

The hospice must routinely provide directly substantially all of the following "core" services: nursing care, medical social services, physicians' services, and counseling services. The remaining "noncore" hospice services may be provided either directly by the hospice or under arrangements with others, in which case the hospice must maintain professional management responsibility for all such services furnished to an individual, regardless of the location or facility in which such services are furnished.

The hospice program must have an interdisciplinary group of personnel which includes at last one physician, one registered professional nurse, and one social worker employed by the hospice, plus at least one pastoral or other counselor.

Other requirements that a hospice must meet include: (1) maintenance of central clinical records on all patients; (2) agreement not to discontinue care to a patient because of the inability of the patient to pay for such care; (3) use of volunteers in the provision of services in accordance with standards set by the Secretary to ensure a continuing level of effort to use volunteers; (4) maintenance of records on the use of volunteers and the cost savings and expansion of care and services achieved through the use of volunteers; (5) licensure in accordance with any applicable State or local law; and (6) meeting other health and safety standards set by the Secretary.

The hospice must be certified to participate in Medicare in accordance with requirements pertaining to a new separate category

of hospice provider. However, where any hospice provider requirements are the same as requirements already met by the provider under other agreements with the Secretary (for example, as a home health agency, skilled nursing facility, or hospital certified to participate in Medicare), then the Secretary will consider the provider to have met those hospice requirements. The Secretary must also coordinate surveys for determining provider certification so as to provide, to the extent feasible, for simultaneous surveys of an entity which seeks to be certified as a hospice program and as a provider of services of another type. Hospices certified as more than one type of provider must have separate provider agreements and must file separate cost reports accounting for services rendered and funds spent in connection with hospice care and any other services provided.

4. Payment for Hospice Care

Reimbursement to hospice providers of services will be an amount equal to the costs which are reasonable and related to the cost of providing hospice care, or which are based on such other tests of reasonableness as the Secretary may prescribe, subject to a "cap amount." This "cap amount" for a year is $6,500 per beneficiary per year adjusted for accounting years that end after October 1, 1984, by the same percentage increase or decrease in the medical care expenditure category of the Consumer Price Index, from March 1984 to the fifth month of the accounting year. The cap amount is applied on an aggregate rather than a case-by-case basis.

5. Waivers of Certain Hospice Requirements

For hospices which began operations before January 1, 1975, the Secretary shall waive until October 1, 1986, those requirements pertaining to: (1) the reimbursement "cap amount"; (2) the limitations on frequency and number of respite care days; and (3) the aggregate limit on number of inpatient care days.

6. Effective Date

Coverage for hospice benefits under Medicare is authorized for the period November 1, 1983 to October 1, 1986. However, an individual who on October 1, 1986, has a hospice election in effect is entitled to hospice benefits after that date for the remainder of the then current election period and for any subsequent consecutive election period to which the individual would have been entitled had the program not expired.

7. Studies and Reports

At the request of the hospice involved, the Secretary is required to continue existing Health Care Financing Administration hospice demonstration projects until the effective date of the Medicare hospice benefit. The Secretary is required to report to Congress prior to September 30, 1983, on the effectiveness of the demonstration projects and certain other matters. In addition, prior to January 1, 1986, the Secretary is required to report to the Congress on whether the reimbursement method and benefit structure (including co-

payments) for hospice care under Medicare are fair and equitable and promote the most efficient provision of care. This report must also include a discussion of the feasibility and advisability of providing for prospective reimbursement for hospice care; an evaluation of the inclusion of payment for outpatient drugs; an evaluation of the need to alter the method of reimbursement for nutritional, dietary, and bereavement counseling as hospice care; and any recommendations for legislative changes in the hospice care reimbursement or benefit structure.

## IV. PROPOSED REGULATIONS

On August 22, 1983, the Health Care Financing Administration, DHHS published proposed regulations which would implement those provisions of the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248, which provide coverage for hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice. Among other things, the regulations would establish requirements for eligibility, covered benefits, services, reimbursement procedures, and the conditions a hospice must meet to be approved for participation in the Medicare program. The following discussion summarizes major provisions of these regulations.

### A. Eligibility and Conditions of Coverage

The hospice care provisions of Public Law 97-248 authorize Medicare Part A coverage for hospice care services provided to individuals who are entitled to Medicare Part A benefits and who are certified to be terminally ill. Part A beneficiaries may elect to receive hospice care in lieu of most other Medicare benefits for up to two periods of 90 days each, plus an additional 30 days.

The statute further provides that for an individual to have payments made on his behalf for hospice care during the first 90-day election period, his attending physician and the medical director (or physician member of the interdisciplinary group) of the hospice providing the care must each certify not later than 2 days after hospice care is initiated that the individual is terminally ill. Attending physician is defined as the physician, who may be employed by a hospice program, whom the beneficiary electing hospice care identifies as having the most significant role in the determination and delivery of medical care to the individual at the time election of hospice care is made. At the beginning of subsequent periods, the medical director or physician member of the interdisciplinary team must recertify that the individual is terminally ill. A beneficiary is considered terminally ill if there is a medical prognosis that his life expectancy is 6 months or less.

The proposed regulations would specify that to be eligible for Medicare coverage of hospice care, an individual must be entitled to Medicare Part A benefits and must be certified as terminally ill. The regulations would use statutory definitions of such terms as "attending physician" and "terminally ill" and refer to the two 90-day periods and one subsequent 30-day period of Medicare's hospice benefit as "election periods."

The proposed regulations further provide that, for the first election period of 90 days, only one certification statement would be required for individuals having no attending physicians. The statute specifies that certification for the first election period be provided

by the attending physician and the medical director physician member of the hospice's interdisciplinary team. The regulations would require certification by the attending physician only if the beneficiary has one. Supplementary information published with the regulations states that this provision is "consistent with Congressional intent to help the individual avoid the need to find a second physician for the sole purpose of obtaining a certification statement."

In addition, the proposed regulations would require that the hospice be responsible for obtaining the certification and recertification statements and for retaining them for verification.

### B. Election and Duration of Hospice Benefits

#### 1. Hospice Election Statements

The statute requires that, for individuals to have payments made on their behalf for hospice care, they must elect to receive that care from a particular hospice.

The regulations provide that in order to elect a particular hospice program, individuals must file an election statement. This election statement must include the following: (1) identification of the particular hospice that will provide care to the individual; (2) the individual's acknowledgment of terminal illness; (3) the individual's acknowledgment that he or she understands that certain Medicare services are waived by the election; (4) the effective date of the election (an individual may designate an effective date that begins with the first day of hospice care or any subsequent day of hospice care, but not a date earlier than the date of election); and (5) the signature of the individual.

The regulations would specify that the two 90-day election periods must be used before the 30-day period. An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods as long as the individual remains in the care of a hospice and does not revoke the election. Supplementary information included with the regulations indicates that when individuals use their election periods consecutively without a break in hospice care, only one election statement would be required for such persons.

The proposed regulations do not include any provision which would allow someone else, such as a legal guardian, to make an election on behalf of a beneficiary. Supplementary information published with the regulations states that a provision of this nature was not included because "an individual waives certain rights to payment in addition to choosing a palliative mode of treatment when hospice care is elected."

#### 2. Waiver of Other Benefits

The proposed regulations would follow the statute closely with regard to provisions requiring hospice beneficiaries to waive certain other Medicare benefits. The statute provides that during the time a hospice election is in effect and except in some exceptional and unusual circumstances as the Secretary provides, the beneficiary will be deemed to have waived entitlement to: (1) hospice care

provided by another hospice program (except when the hospice, from which the individual elects to receive care, makes arrangements with another hospice to provide services it does not offer directly); and (2) any Medicare services related to the treatment of the individual's terminal illness or services equivalent to or duplicative of hospice care. However, the waiver does not apply to services provided by the beneficiary's attending physician if the attending physician is not employed by the hospice program. Further, the waiver only applies to services provided by or under arrangements with the hospice.

The statute provides that an individual, upon making an election to receive hospice coverage, would be deemed to have waived payments for certain other benefits except in "exceptional and unusual circumstances as the Secretary may provide." The regulations do not specify any exceptional or unusual circumstances, because, as supplementary information included with the regulations states, HCFA does not yet know of specific types of circumstances that may warrant the use of this exception.

In addition, the statute authorizes the Secretary to establish guidelines to stipulate what services are waived that are related to the treatment of the individual's terminal condition or are the equivalent of hospice care. The proposed regulations do not enumerate the specific services that the Secretary might consider related or equivalent to hospice care. Supplementary information published with the regulations indicates that this has not been done because there are many illnesses which may occur when an individual is terminally ill which are brought on by the underlying condition of the patient. This supplementary information states that it is not unusual for a terminally ill patient to develop pneumonia or some other illness as the result of his or her weakened condition. Treatment of such illnesses would be considered a hospice service and payment of other Medicare benefits would be waived by the hospice election.

### 3. Revoking the Election of Hospice Care

The statute provides that, after an individual makes a hospice election, he may subsequently revoke it; however, he will be deemed to have used benefits for the entire election period then in effect. Any time after revocation, he may execute a new election for a subsequent period if he is otherwise entitled to hospice benefits. In addition, once each election period, the individual may change hospice programs.

The regulations would provide that in order for an individual to revoke the election of hospice care, he would be required to file with the hospice a revocation statement. This statement would be required to include (1) a signed statement that the individual revokes his or her election for Medicare coverage of hospice care for the remainder of that election period; and (2) the date that the revocation is to be effective (the individual could not designate an effective date earlier than the date revocation is made).

The regulations would also provide procedures for the individual to change hospices. To change the designation of hospice programs, the individual would be required to file, with the hospice from

which he or she has received care and with the newly designated hospice, a statement that includes (1) the name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care; and (2) the date the change is to be effective. The regulations also specify that the change would not be considered a revocation of the decision to receive hospice care for that particular election period.

### C. Covered Services

The statute requires that hospice services, to be covered by Medicare, must be reasonable and necessary for the palliation or management of terminal illness. In addition, an individual electing hospice care through a particular hospice program must have a written plan established for the care to be provided. This written plan must be established before care is actually provided and must be reviewed by the individual's attending physician and by the medical director and the interdisciplinary group of the hospice.

The regulations contain these general requirements, in addition to the statute's listing of covered services. In certain instances, the regulations include additional specifications for these services. Covered hospices services as detailed in the regulations would include the following:

(1) Nursing care provided by or under the supervision of a registered nurse.

(2) Medical social services provided by a social worker under the direction of a physician.

(3) Physicians' services performed by a physician as defined in current Medicare regulations, except that the services of the hospice medical director or the physician member of the hospice's interdisciplinary group must be performed by a doctor of medicine or osteopathy.

(4) Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling may be provided both for the purpose of training the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. While hospices are required to provide bereavement counseling, reimbursement is not provided for this benefit.

(5) Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital, SNF, or ICF that additionally meets the proposed new standards for freestanding hospices, regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management. Inpatient care may also be furnished as a means of providing respite for the individual's family or other persons caring for the individual at home. Payment for inpatient care would be made at the rate specified in other proposed regulations described later.

(6) Medical appliances and supplies, including drugs and biologicals. Only drugs as defined in the Medicare statute and which are used primarily for the relief of pain and symptom control related

to the individual's terminal illness would be covered. Appliances could include covered durable medical equipment as described in existing Medicare regulations as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment would be provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care.

(7) Home health aide services furnished by qualified aides and homemaker services. Home health aides may provide personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to participate in the treatment plan.

(8) Physical therapy, occupational therapy, and speech-language pathology services provided for purposes of symptom control or to enable the patient to maintain activities of daily living and basic functional skills.

The statute specifies that nursing care and home health aide and homemaker services may be provided on a 24-hour continuous basis only during periods of crisis and only as necessary to maintain the terminally ill individual at home. The regulations would define a period of crisis as one in which the individual requires continuous care to achieve palliation or management of acute medical symptoms. The regulations further specify that homemaker or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis, but care during these periods must be predominantly nursing care.

With regard to respite care, the statute specifies that it may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than 5 days. The regulations would define respite care as short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual. The regulations also specify that respite care may be provided only or an occasional basis and may not be reimbursed for more than 5 consecutive days at a time.

## D. Conditions of Participation

### 1. "Core" and "Non-Core" Services

The statute provides that hospice programs will be eligible to participate in Medicare if they are public agencies or private organizations primarily engaged in providing the hospice services described above. In addition, hospices would be required to provide bereavement counseling. (Bereavement counseling is a required hospice service but it is not reimbursable.) Hospices would also be required to make these services available (as needed) on a 24-hour basis, in individuals' homes, on an outpatient basis, and on a short-

term inpatient basis. The statute further requires that a hospice routinely provide directly substantially all of the following services, often referred to as "core" services: nursing care, medical social services, physicians' services, and counseling services. The remaining "non-core" hospice services may be provided either directly by the hospice or under arrangements with others, in which case the hospice must maintain professional management responsibility for all such services to an individual, regardless of the location or facility in which these services are provided.

The regulations on core services would require a hospice to ensure that substantially all the core services indicated above be routinely provided directly by hospice employees. The regulations further specify that a hospice may use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice would be required to maintain professional, financial, and administrative responsibility for the services and must assure that the qualifications of staff and services provided meet the requirements specified in core services regulations.

Supplementary information published with the regulations notes that the distinction in the law and legislative history between those services that must be furnished directly and those that may be furnished under arrangements mandates that HCFA define "directly" to require that services be provided by hospice employees. In addition, the supplementary information indicates that in cases where a hospice is a separately certified unit of another organization, the regulations' definition of "employee" would require that the individual be assigned and work substantially full-time for the hospice unit. According to HCFA, this requirement ensures that core services are provided by employees responsible to the hospice but would not preclude them from providing services outside the hospice unit. The supplementary information also points out that the definition of employee has been drafted to include volunteers, in order to encourage greater use of volunteers.

With regard to definitions of "routinely" and "substantially" as they apply to core services, HCFA believes that these terms should be construed to mean that the services provided directly by the hospice should be adequate to meet the needs of the hospice's average patient load. The supplementary information indicates, by way of example, that physician services, to meet this requirement, should be sufficient to meet the general needs of the hospice, i.e., the need for a medical director, an interdisciplinary group member, and the general day-to-day, hands-on medical services required by hospice patients. Only physician services of a specialized nature, for example, radiologists, anesthesiologists, and orthopedic surgeons, would appropriately be obtained under arrangements.

With regard to specific core services, the proposed regulations specify additional conditions.

(a) Nursing services: The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must be directed and staffed to assure that the nursing needs of patients are met. Patient care responsibilities of nursing

personnel must be specified and services must be provided in accordance with recognized standards of practice.

(b) Medical social services: Medical social services must be provided by a qualified social worker, under the direction of a physician.

(c) Physician services: Physician employees of the hospice, including the physician member(s) of the interdisciplinary group, must care for the general medical needs of the patients for palliation and management of terminal illness and related conditions.

(d) Counseling services: Counseling services must be available to both the individual and the family. Counseling includes bereavement counseling, dietary, spiritual, and any other counseling services for the individual and family while the individual is enrolled in the hospice. With regard to bereavement counseling, the regulations also specify that there must be an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided (up to one year following the death of the patient) and the frequency of service delivery.

For non-core services, the regulations would provide that these services could be provided directly by hospice employees or under arrangements made by the hospice. For each of the non-core services, the regulations specify additional conditions.

(a) Physical therapy, occupational therapy, and speech-language pathology services: These services must be available, and when provided, offered in a manner consistent with accepted standards of practice.

(b) Home health aide and homemaker services: Home health aide and homemaker services must be available and adequate in number to meet the needs of the patients. A home health aide is a person who meets the training and skill requirements specified in existing Medicare regulations. Aide services must be provided under the general supervision of a registered nurse who makes a supervisory visit to the home health site at least every two weeks to assess relationships and determine whether goals are being met. Written instructions for patient care must be prepared by a registered nurse.

(c) Medical supplies: Medical supplies and appliances, including drugs and biologicals, must be provided as needed for the palliation and management of the terminal illness and related conditions. All drugs and biologicals must be administered in accordance with acceptable standards of practice. Other regulations for drugs specify orders for medications; administration of pharmaceuticals; drug records and disposition; drug storage and security; and drug disposal.

(d) Short-term inpatient care: Inpatient care must be available for pain control, symptom management, and respite purposes. Inpatient care must be provided in one of the following participating Medicare or Medicaid facilities that is most appropriate to the needs of the individual: a freestanding hospice with an inpatient unit, a hospital, a skilled nursing facility (SNF), or an intermediate care facility (ICF) that meets additional proposed standards regarding staffing and patient areas. With regard to the statute's limita-

tion on inpatient care, the regulations provide that the total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in any 12-month period preceding a certification survey in a particular hospice may not exceed 20 percent of the total number of hospice days for this group of beneficiaries.

### 2. Other Administrative and Organizational Requirements for Hospices

The statute requires hospices to meet a number of other requirements including those dealing with an interdisciplinary group of personnel, maintenance of clinical records, an agreement not to discontinue care to a patient because of the inability of the patient to pay for care, use of volunteers, licensure in accordance with State laws, and meeting other health and safety standards set by the Secretary.

The proposed regulations would elaborate on these requirements to specify the following conditions which a hospice must meet in order to participate in Medicare.

#### A. GOVERNING BODY

A hospice must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the hospice's total operation. The governing body must also ensure that all services provided are consistent with accepted standards of practice.

#### B. MEDICAL DIRECTOR

The hospice must have a medical director who must be a doctor of medicine or osteopathy who assumes overall responsibility for the hospice's patient care program.

#### C. PROFESSIONAL MANAGEMENT

If a hospice arranges for another entity to furnish services to the hospice's patients, the hospice must meet the following standards: (1) the hospice program must assure the continuity of patient/family care in home, outpatient, and inpatient settings through a defined process detailed in the regulations; (2) the hospice must have a legally binding written agreement for the provision of services; (3) the hospice must retain professional management responsibility for contracted services and ensure that they are furnished in a safe and effective manner by employees meeting qualifications specified in regulations and in accordance with requirements prescribed by these regulations; (4) the hospice must retain responsibility for payment for services; (5) the hospice must ensure that inpatient care is furnished only in a facility which meets the requirements for such care specified in the regulations and its arrangement for inpatient care is described in a legally binding written agreement which includes, at a minimum, certain information specified in the regulations.

### D. PLAN OF CARE

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan. The plan must be established by the attending physician, the medical director, and interdisciplinary group prior to providing care. The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, the medical director, and interdisciplinary group. These reviews must be documented. The plan must include assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

### E. CONTINUATION OF CARE

A hospice may not discontinue or diminish care provided to an individual because of the individual's inability to pay for care. Supplementary information published with the regulations indicates that this requirement would apply to any individual receiving care from the hospice. With respect to those individuals who are Medicare beneficiaries, supplementary information adds that this provision would require continuation of hospice services even after the individual exhausts the hospice benefits under Medicare as long as the individual continues to desire to receive hospice services and is terminally ill.

### F. INFORMED CONSENT

A hospice must demonstrate respect for an individual's rights by ensuring that every individual has signed an informed consent form that specifies the type of care and services that may be provided as hospice care during the course of illness.

### G. IN-SERVICE TRAINING

A hospice must provide an ongoing program for the training and continuing education of its employees.

### H. QUALITY ASSURANCE

A hospice must conduct an ongoing, comprehensive, integrated self-assessment of the quality and appropriateness of care provided, including inpatient care and family care. The findings would be used by the hospice to correct identified problems and to revise hospice policies if necessary.

### I. INTERDISCIPLINARY GROUP

The hospice must designate an interdisciplinary group composed of hospice employees to provide or supervise the care and services offered by the hospice. This group must include at least a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor. The hospice must also designate a registered nurse to coordinate the overall plan of care for each patient. Supplementary information submitted with the regulations

indicates that the interdisciplinary group could be composed of paid hospice employees as well as hospice volunteers as long as the individuals in the group meet the appropriate qualifications. The information adds that regulations require a registered nurse to be coordinator of the overall plan of care because HCFA believes that an understanding of the medical regimen being provided is essential, and that a registered nurse has the general knowledge required for the coordination of all other services being provided.

#### J. VOLUNTEERS

The hospice must use volunteers, in defined roles, under the supervision of designated qualified hospice staff members. Appropriate orientation and training must be provided by the hospice to volunteers. Volunteers may be used in administrative and direct patient care roles. However, any direct patient care delivered by volunteers must be consistent with the interdisciplinary group plan of care and the volunteer's skills and qualifications. The hospice must document active and ongoing efforts to recruit and retain volunteers. The hospice must also document the cost savings achieved through the use of volunteers, including identification of necessary positions which were occupied by the volunteers, the work time spent by these persons, and estimates of the dollar costs which the hospice would have incurred if paid employees had occupied volunteer positions. The hospice must document a continuing level of volunteer activity. Expansion of care and services achieved through the use of volunteers, including the type of services and the time worked, must be recorded. In addition, the regulations on volunteers require the hospice to make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to patients who desire such visits and to advise patients of this opportunity.

#### K. LICENSURE

If State or local law provides for licensing of hospice, the hospice must be licensed. Employees who provide services must be licensed, certified, or registered in accordance with applicable State laws.

#### L. CENTRAL CLINICAL RECORDS

In accordance with accepted principles of practice, the hospice must establish and maintain a clinical record of every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible, and systematically organized to facilitate retrieval. Additional standards are also specified for the content of these records and protection of information contained in them.

### 3. Freestanding Hospice with Inpatient Unit

The regulations specify separate conditions of participation for freestanding hospices providing inpatient care directly. Freestanding hospices providing inpatient care directly would be required to comply with standards for staffing, health and safety, fire protection, patient areas, patients' rooms, administering medications, and

supervision, among others. Supplementary information included with the regulations indicates that many of these proposed standards already exist for intermediate care facilities participating in Medicaid.

### E. Hospice Certification and Provider Agreements

The statute authorizes the Secretary to use State survey agencies to determine a hospice's compliance with the conditions of participation. The proposed regulations would amend existing Medicare regulations to include hospices as providers that must be certified in accordance with already established procedures.

The statute also provides that if the Secretary finds that a national accrediting body provides reasonable assurance that the conditions of participation are met by hospices, the Secretary may then treat an institution accredited by the body as meeting Medicare conditions. This exception to the usual approval procedures is commonly referred to as extending "deemed status" to the provider. Supplementary information submitted with the regulations states that while HCFA is aware that the Joint Commission on Accreditation of Hospitals (JCAH) is developing standards for hospices, it would be premature to make a decision on deeming hospices accredited by JCAH or by any other accreditation program until a survey process is begun and HCFA gains experience to assess the efficacy of enforcement. HCFA also believes that, because of the sunset provision of the hospice benefit, 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 statute further provides that where any hospice provider requirements are the same as requirements already met by the provider under other agreements with the Secretary (for example, as a home health agency, skilled nursing facility, or hospital certified to participate in Medicare), then the Secretary will consider the provider to have met the hospice requirements. The Secretary must also coordinate certification surveys so as to allow simultaneous surveys of an entity which seeks to be certified as a hospice program and as a provider of services of another type. Supplementary information published with the regulations states that new regulations are not needed to address these provisions. According to HCFA, State survey agencies already follow, as a matter of economic efficiency, this procedure for other types of dually certified providers.

The statute requires that hospices certified as more than one type of provider must have separate provider agreements and must file separate cost reports. The proposed regulations would amend existing Medicare regulations to include hospices as providers that must have an agreement with HCFA.

In addition, proposed regulations would specify, in accordance with the statute, that if an agreement between the Secretary and a hospice is terminated, there would be no reimbursement for hospice care provided under a plan of care that is established on or after the effective date of termination. If the plan is established for an individual before the effective date of termination, there would

be no reimbursement for services provided after the calendar year in which the termination is effective.

## F. Reimbursement

### 1. General

The statute provides that reimbursement to hospice providers of services will be an amount equal to the costs which are reasonable and related to the cost of providing hospice care, or which are based on such other tests of reasonableness as the Secretary may prescribe, subject to a "cap amount." The cap amount for a beneficiary for a year is $6,500, adjusted for accounting years that end after October 1, 1984, by the same percentage increase or decrease in the medical care expenditure category of the Consumer Price Index, from March 1984 to the fifth month of the accounting year.

Supplementary information included with the proposed regulations states that the reimbursement provisions of the statute provide the Secretary considerable discretion in designing a reimbursement method for hospice care. With this authority, HCFA proposes to use a prospective cost-based payment methodology for hospice care. Under this proposed methodology, hospices would generally be paid one of several predetermined rates for each day a Medicare beneficiary is under the care of the hospice. The rates would vary according to the level of care furnished to the beneficiary. As proposed, total reimbursement to a hospice for care furnished to the Medicare beneficiary would vary by the length of the patient's coverage period in the hospice as well as by the characteristics of the services (with respect to intensity and site) furnished to the beneficiary.

The regulations would establish four basic payment categories:

#### A. ROUTINE HOME CARE DAY

A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous home care. The supplementary information adds that the routine home care rate would be paid for every day a patient is at home and under the care of the hospice (and not receiving continuous home care), regardless of the volume or intensity of the services provided on any given day. The supplementary information states that hospice demonstration projects have shown that hospice patients require a sufficiently intensive level of home care so that HCFA expects there will be few days when services will not be required. According to HCFA, payments of an average rate for every day of routine home care permits the hospice to provide the needed care in the most efficient and convenient method possible without the need to deal with the various coverage and payment rules that would be required if a more detailed and service-oriented payment system were implemented.

#### B. CONTINUOUS HOME CARE DAY

A continuous home care day is a day on which an individual who has elected to receive hospice care receives hospice care consisting predominantly of nursing care on a continuous basis at home.

Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is furnished only during brief periods of crisis and only as necessary to maintain the terminally ill patient at home. Home care would have to be provided for a period of at least 8 hours before it would be considered to fall within the category of continuous home care. Supplementary information published with the regulations states that this threshold has been established because demonstration data indicate that when this type of care is furnished, it rarely occurs for periods of less than this duration.

The hospice payment for a continuous home care day would vary according to the length of continuous services provided, as follows:

—For 8 and less than 16 hours of care, the hospice would be paid one-half a specified rate.

—For 16 and less than 20 hours of care, the hospice would be paid three-fourths of the rate.

—For 20 through 24 hours of care, the hospice would be paid eleven-twelfths of the rate.

### C. INPATIENT RESPITE CARE DAY

An inpatient respite care day is one on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for the respite of his caretakers. The supplementary information included with the regulations adds that the inpatient respite rate would apply specifically to situations where the patient's family members or other persons caring for the patient need a short period of relief. Inpatient respite care may be provided only on a intermittent, nonroutine, and occasional basis and may not be reimbursed for more than 5 days at a time.

According to HCFA, the payment made for inpatient respite care should reflect the fact that this care can be appropriately purchased in a SNF or ICF rather than in a more expensive setting. The regulations therefore propose that the basic rate for this level of care would be the same regardless of the type of facility in which care is furnished, that is, freestanding hospice, hospital, SNF, or ICF. The inpatient respite care rate would be paid for the date of admission and for each subsequent inpatient day, except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate would be paid to the hospice.

### D. GENERAL INPATIENT CARE DAY

A general inpatient care day is one on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. The supplementary information included with the regulations adds, by way of example, that payment would be made at this rate for situations when the patient's condition is such that it is no longer possible to maintain the patient at home and when care in an inpatient facility is needed for the performance of complicated procedures necessary for pain control or acute or chronic symptom management.

## 2. Payment Rates for Hospice Care

The proposed regulations specify that payment rates for each of the categories of hospice care would be equal to a prospectively determined amount which HCFA estimates equals the costs incurred by hospices generally in efficiently providing that type of hospice care to Medicare beneficiaries.

The supplementary information published with the regulations indicates that the proposed prospective payment rates for hospice care have been derived in general from data obtained from the Medicare hospice demonstration project. In calculating the proposed amounts, HCFA has relied on data concerning the kinds of services furnished by hospices, the cost of such services, and the frequency with which such services were furnished to hospice patients under the demonstration hospice programs. HCFA has also included overhead costs such as maintenance, depreciation, general accounting, capital and other administrative costs in the calculation of the individual service components (for example, nursing or home health services) that compose the payment rates. According to HCFA, the demonstration data will ultimately reflect the experience of more than 6,000 Medicare patients who received care from the 26 demonstration hospices during the course of the demonstration.

The regulations propose the following daily payment rates for each of the four categories of hospice care:

| | |
|---|---|
| 1. Routine home care (per day) | $53.17 |
| 2. Continuous home care: | |
| 8 up to 16 hours | 155.98 |
| 16 up to 20 hours | 233.97 |
| 20 through 24 hours | 285.96 |
| 3. Inpatient respite care (per day) | 61.65 |
| 4. General inpatient care (per day) | 271.00 |

Supplementary information included with the regulations discusses in detail the data and calculations used to arrive at these individual prospective payment rates. Among other things, this information points out that while the payment rates for inpatient respite care and general inpatient care include adjustments for inflation, as reflected in the medical care expenditure category of the Consumer Price Index, the prospective home care rates have not been adjusted for inflation and reflect the 1981 cost experience of demonstration hospices. HCFA has not adjusted the routine and continuous home care rates for inflation occurring from 1981 to the date of implementation of hospice reimbursement.

The supplementary information published with the regulations adds that HCFA is not proposing any specific mechanism to adjust the prospective rates after reimbursement has begun. Rather HCFA will monitor the cost and utilization experience of participating hospices through the submission of cost reports filed by selected hospices.

### 3. Local Adjustment of Payment Rates

The regulations propose to adjust the prospective payment rates for each of the categories of hospice care to reflect local differences in wages. The supplementary information published with the regulations indicates that HCFA would use the area wage index currently used by the Medicare program in establishing reimbursement limits for hospitals, skilled nursing facilities, and home health agencies. This index relates the wage levels in each Standard Metropolitan Statistical Area, New England County Metropolitan Area, and rural area within a State to a national norm of 1.0. This index is calculated based on data compiled by the Bureau of Labor Statistics and is updated annually.

In adjusting the payment rates for differences in area wage levels, HCFA would separate the national payment rates into components which reflect the estimated proportion of the rate attributable to wage and non-wage costs. Then the wage component of each rate would be adjusted by the index applicable to the area in which the hospice is located. The rate to be paid to a hospice would be the sum of the unadjusted non-wage component and the adjusted wage component.

### 4. Limitation on Maximum Number of Inpatient Care Days

The statute requires that hospices provide assurances that the aggregate number of inpatient days provided in any 12-month period to individuals electing a particular hospice program not exceed 20 percent of the aggregate number of days of hospice care provided to Medicare beneficiaries during that period.

The regulations would require that hospices refund reimbursements made for inpatient care provided in excess of this 20 percent limit. In addition, the regulations would apply this limitation prior to the application of the hospice cap. The intermediary administering the hospice program in an area would calculate a limitation on payment for inpatient care to ensure that Medicare payment is not made for days of inpatient care (both general and respite) in excess of 20 percent of the total number of days of hospice care furnished to Medicare patients. If the number of days of inpatient care furnished to Medicare patients is equal to or less than 20 percent of the total days of hospice care to Medicare patients, no adjustment would be necessary. If the total number of days of inpatient care exceeded the maximum allowable number, the limitation would be determined by calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made. Any excess reimbursement would be refunded by the hospice.

### 5. Adjustment for Physicians' Services

The statute requires that hospices include among their core services the services of physicians. The proposed regulations would include in the prospective payment rates the following services performed by hospice physicians: the general supervisory services of

the medical director, and the interdisciplinary group services performed by physician members.

However, for other types of physician services, supplementary information published with the regulations indicates that available data did not permit HCFA to develop an accurate prospective estimation of the cost a hospice incurs for these professional services. HCFA maintains that these services cannot be incorporated into any of its models of services for determining prospective payments because they do not occur frequently or uniformly in the care of a typical hospice patient. The regulations therefore propose to reimburse the hospice separately for these services.

Specifically, the regulations provide that the hospice would be paid for these other physician services that are furnished to individual patients and that are provided by hospice employees (excluding volunteers) or under arrangements made by the hospice at 100 percent of the Medicare reasonable charge for the service. The hospice would bill these services to its Medicare carrier. Total payments made to the hospice for these services would be counted, along with total payments made at the prospective payment rates, in determining whether the hospice cap amount had been exceeded.

The regulations also provide that the services of a beneficiary's attending physician, who is not an employee of the hospice or providing services under arrangements with the hospice, would not be considered hospice services and would not be included in the amount subject to the hospice cap. Attending physician services would continue to be paid at the usual Medicare rate of 80 percent of reasonable charges.

## G. Coinsurance

The statute requires that the amount payable for hospice care be reduced by a coinsurance amount for drugs and biologicals provided on an outpatient basis, and for respite care. No other cost sharing charges are permitted for hospice services provided during the period of a hospice election.

### 1. Drugs and Biologicals

With regard to drugs and biologicals provided on an outpatient basis, the statute requires hospice programs to establish drug co-payment schedules. Beneficiary charges, not to exceed $5 per prescription, are to approximate five percent of the cost of the drug to the hospice program.

In addition to these specifications, the regulations would require that the cost of the drug or biological not exceed what a prudent buyer would pay in similar circumstances. The drug co-payment schedule would also have to be reviewed for reasonableness and approved by the intermediary before it is used by the hospice.

Supplementary information published with the regulations points out that since there is no cumulative maximum coinsurance for drugs and biologicals specified in the statute, the coinsurance payment would be applicable for each prescription furnished by the hospice.

This supplementary information adds that for the prospective payment rates for routine home care and continuous home care, the application and collection of copayments by the hospice would be assumed. Before the final prospective rates were calculated, HCFA would reduce the portion of these rates attributable to drugs by the average coinsurance expected to be collected by the hospice. HCFA has estimated the amount of this offset from cost and utilization data collected from the Medicare demonstration project.

### 2. Respite Care

For respite care, the statute provides that coinsurance charges would be equal to 5 percent of the estimated payments to the hospice program for respite services. However, the total amount of coinsurance for respite care could not exceed the amount of the inpatient hospital deductible applicable during the period of hospice election, as long as the hospice election is not broken, as explained below, by more than 14 days.

Supplementary information included with the regulations adds, by way of example, that if a beneficiary elects to use all three of his election periods consecutively without a two week break, he or she would be subject to a maximum coinsurance for respite care equal to the hospital inpatient deductible. Similarly, if a break between election periods exceeds 14 days, the maximum coinsurance for respite care would double or triple, depending on the number of election periods used and the timing of subsequent elections.

As HCFA is proposing for the drug coinsurance, the prospective payment rate for inpatient respite care would be reduced by the average amount of respite coinsurance expected to be collected by the hospice. Thus, before the final rate for inpatient respite care is calculated, HCFA would reduce the estimated payment for inpatient care by the projected average coinsurance amount. The hospice would then be responsible for billing and collecting the coinsurance amounts from the beneficiary.

The supplementary information also points out that the regulations do not propose a separate limit for respite care after an individual reaches the inpatient hospital deductible amount. According to HCFA, it is highly unlikely that the beneficiary will exceed this limit on copayment, since in order for this to occur, more than 93 days of inpatient respite care would need to be received. Both the 20 percent limit on inpatient days and the requirement that respite care not be provided for more than 5 consecutive days would serve to reduce the possibility that an individual would receive 93 days of inpatient respite care.

### 3. Individual Liability for Services That Are Not Considered Hospice Care

The regulations provide that Medicare payment to the hospice discharges an individual's liability for payment for all services that are considered covered hospice care, except for hospice coinsurance amounts for drugs and biologicals and for respite care. The individual would be liable for the Medicare deductibles and coinsurance payments and for the difference between the reasonable and actual charge on unassigned claims for other covered services that are not

considered hospice care. The regulations cite as examples of services not considered hospice care services furnished before or after a hospice election period; services of the individual's attending physician, if the physician is not an employee of or working under an arrangement with the hospice; or Medicare services received for the treatment of an illness or injury not related to the individual's terminal conditions.

## H. Intermediaries

The statute requires the Secretary to designate intermediaries to serve hospices. The statute also specifies that for those hospices which are sub-divisions of another Medicare certified provider, the Secretary give special consideration to the intermediary already serving that provider.

Intermediaries are responsible for much of the day-to-day operational administration of the Hospital Insurance (Part A) program of Medicare. Their responsibilities include determining the reasonable cost of provider services, paying claims, offering consultative services to providers, communicating HCFA information and instructions, and conducting provider audits.

The proposed regulations would amend existing Medicare regulations to prohibit a hospice from electing, nominating, or changing an intermediary as other providers are permitted to do. According to the supplementary information submitted with the regulations, because the statute requires the Secretary to designate intermediaries to serve hospices, notwithstanding any other provision of Medicare law, the statute does not give hospices the option to choose an intermediary.

Existing regulations would also be amended to specify that freestanding hospices and hospices whose parent providers are served by HCFA rather than an area intermediary, would receive payment for covered hospice services through an intermediary designated by HCFA. Any other provider-based hospice would be served by the same intermediary that serves its parent provider.

Supplementary information published with the regulations adds that HCFA would designate one intermediary per State to serve the freestanding hospices, except that certain designated intermediaries would serve freestanding hospices across State lines in keeping with their longstanding service area. This supplementary information states that the designation of one intermediary per State to serve freestanding hospices would help intermediaries that are designated to reimburse hospices to coordinate their activities with the local intermediaries and carriers that handle bills for services not related to terminal diagnosis and services provided by an attending physican not employed by the hospice.

## V. ISSUES

### A. Prospective Reimbursement

The statute provides that hospices will be paid amounts equal to the costs which are reasonable and related to the cost of providing hospice care, or which are based on such other tests of reasonableness as the Secretary may prescribe, subject to a "cap amount." The statute also requires the Secretary to report to the Congress prior to January 1, 1986, on the feasibility and advisability of providing for prospective reimbursement for hospice care. The proposed regulations for hospice care under Medicare would establish a prospective payment system for hospices. Under this proposed methodology, hospices would generally be paid one of several predetermined rates for each day in which a Medicare beneficiary is under the care of the hospice. The rates would vary according to the level of care furnished to the beneficiary.

Some have questioned whether Congress intended that a prospective payment system be established for hospice care at the implementation of the benefits. It should be noted that the Congress did not preclude such action. With respect to prospective payment generally, the Congress has already established such a system for inpatient hospital services under Medicare and has required the Secretary to study and make recommendations for the prospective payment of long-term care and physician services under Medicare. According to a recent GAO report, "The statute provides the Secretary discretion to fix a payment mechanism in accord with the requirements set forth therein. A prospective reimbursement system is consistent with this grant of authority. Moreover, the Secretary has interpreted similar language used elsewhere in the Social Security Act to authorize prospective reimbursement." (GAD/HRD–83–72, July 12, 1983)

Questions arise as to the adequacy of the data base used to determine the proposed payment rates. In general, the proposed prospective payment rates for hospice care were derived from data obtained from the medicare hospice demonstration project involving 26 hospice programs. Currently, the Joint Commission on Hospital Accreditation estimates that there may be as many as 1,145 hospices in the country.

### B. Hospice Cap

The initial cap amount for hospice reimbursement is set at $6,500 and is applied on an aggregate basis. A preliminary analysis of data collected under the Medicare hospice demonstration project for 597 demonstration patients in 14 home health agency-based hospices and 307 patients in 11 hospital-based hospices indicates that estimated total 1981 costs per patient were $4,026 for home health agency-based patients and $6,511 for hospital-based agency

patients. For these preliminary estimates, patients with very short stays (3 days and less) and those patients with long lengths of stay in the hospice program (over 180 days) were under-represented.

Questions arise as to the number and types of hospices which will be able to provide care within the cap amount specified in the law. Other questions arise as to the extent to which hospice patients might be encouraged by their hospice to revoke their hospice care benefit and resume regular Medicare coverage, if the cost of their hospice care is unusually expensive. The regulations acknowledge that it will be necessary to closely monitor the incidence of hospice elections and revocations in connection with non-hospice Medicare admissions to hospitals to assure that manipulation and coercion do not take place.

### C. Regional Adjustments for the Hospice Cap

The cap amount for hospice reimbursement of $6,500 is an absolute cap in all areas of the country.

Questions arise as to whether adjustments should be permitted in this cap amount to reflect the varying costs of delivering health care in different regions of the country.

### D. Adjustment of Payment Rates

Supplementary information included with the regulations indicates that HCFA, in calculating prospective payment rates for inpatient respite and inpatient general care, made adjustments in base year data for increases in the medical care component of the Consumer Price Index (CPI). The prospective home care rates, on the other hand, reflect only the 1981 cost experience of demonstration hospices. The supplementary information states that HCFA is not proposing to adjust these rates for inflation that occurred from 1981 to the date of implementation of hospice reimbursement, for the following reasons: The home care rates reflecting hospice demonstration experience have built into them certain overhead costs, such as data collection, that are not covered under the hospice benefit. In addition, since hospices were reimbursed for costs and there were no tests of "reasonableness" applied, there were no incentives for efficiency. Some hospices also had a low volume of services with resulting higher costs per visit.

Questions can be asked as to why inpatient care rates were adjusted by the medical care component of the CPI, rather than the hospital room component of the CPI. In addition, other questions arise as to whether in the routine and continuous home care rates, adjustments for inflation should have been applied to the nursing, home health, therapy, and drug components of these categories of hospice care services.

### E. "Core" Services

The statute provides that hospices must routinely provide directly, substantially all of the following "core" services: nursing care, medical social services, physicians' services, and counseling services. The remaining "non-core" hospice services, may be provided either directly by the hospice or under arrangements with other

providers. These services include physical therapy, occupational therapy and speech-language pathology services; home health aide and homemaker services; medical supplies, including drugs and biologicals; and short-term inpatient care. For non-core services, the hospice would be required to maintain professional management responsibility for all such services furnished to the individual, regardless of the location or facility in which such services are furnished.

With regard to core services, the proposed regulations define "directly" to require that services be provided by hospice employees. In addition, supplementary information published with the regulations indicates that HCFA has defined "routinely and substantially" to mean that the services provided directly by the hospice should be adequate to meet the general needs of the hospice. Therefore, physician services to meet this requirement, would need to be sufficient for day-to-day, hands-on medical services and only physician services of a specialized nature (e.g., radiologists) could appropriately be obtained under arrangements. In addition, a hospice could use contracted staff for core services to supplement hospice employees during periods of peak patient loads. The proposed regulations raise questions as to whether all core services should be provided by hospice employees and whether there should be other circumstances in which a hospice would be permitted to provide such services under arrangements with other providers. For example, some existing hospice programs provide nursing care services exclusively through arrangements with other providers. Under current law, these programs would be excluded from participation unless they altered their established mode of operations.

### F. Limits on Inpatient Care

The statute requires a hospice to ensure that the total number of inpatient care days used by Medicare beneficiaries who elected hospice coverage in any 12-month period not exceed 20 percent of the aggregate number of days of hospice care provided to Medicare beneficiaries during that period. In addition, inpatient respite care may be provided only on an intermittent, non-routine, and occasional basis and may not be provided for more than 5 days at a time.

Questions arise as to the monitoring procedures which will be necessary to assure that patients do not revoke their election of hospice care when hospices may not be able to meet these statutory limits. In addition, other questions can be asked as to whether hospices should be required to refund reimbursements made for inpatient care provided in excess of this 20 percent limit. The statute requires as a condition of participation that hospices simply provide assurances that inpatient care not exceed this limit. A question arises as to whether hospices, not initially meeting this requirement, could be required to undertake a plan to correct this condition of participation before having reimbursements reduced.

### G. General Inpatient Care Payment Rate

The regulations propose to establish a payment rate for general inpatient care. The regulations specify that a general inpatient

care day is one on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. The supplementary information included with the regulations adds, by way of example, that payment would be made at this rate ($271 per day) for situations when the patient's condition is such that it is no longer possible to maintain the patient at home and when care in an inpatient facility is needed for the performance of complicated procedures necessary for pain control or acute or chronic symptom management.

Congress recently enacted legislation, the Social Security Amendments of 1983, P.L. 98-21, which contains provisions requiring the Secretary of DHHS to establish a new prospective payment system for the reimbursement of hospitals under the Medicare program. Under these provisions, hospitals will be reimbursed a set payment amount for each type of care which will be classified by diagnosis related group (DRG). Questions may be asked as to whether a DRG can be developed for general inpatient hospice care and whether a DRG payment rate can be incorporated into the proposed prospective payment rates for hospice care.

### H. Reporting and Recordkeeping Requirements

The regulations on prospective payments for hospice care require hospices to provide reports and keep records as the Secretary determines necessary to administer the program. Supplementary information included with the regulations adds that prospective payment for hospice care enables HCFA to design a system of reporting requirements which is less comprehensive than the requirements that are necessary to operate a retrospective cost-based system. According to this supplementary information, HCFA is developing cost reporting forms and will distribute them upon completion to hospices so that they can make any changes needed in their recordkeeping systems to collect the necessary information. The supplementary information also states that HCFA is not proposing any specific mechanism to adjust the prospective rates after reimbursement has begun. Rather, HCFA will monitor the cost and utilization experience of participating hospices through the submission of cost reports filed by selected hospices and will adjust the rates as an examination of these reports dictates.

Questions arise as to the comprehensiveness of the information which will be collected by HCFA and the reliability of data from selected hospices used to update payment rates for care. In addition, other questions arise as to the procedures and audits HCFA will use to assure that the hospice benefit will be provided as intended by law, that billed-for-services have been furnished, and that other requirements for participation and payment are met. Supplementary information published with the regulations indicates that HCFA will establish a system for monitoring hospice care for these purposes, but does not elaborate on its details.

### I. Medicare Coverage for Conditions Unrelated to Hospice Care

The statute and regulations provide that an individual must waive all rights to Medicare payments for the duration of the elec-

tion of hospice care for the following services: (1) hospice care provided by a hospice other than the hospice designated by the individual, unless the services are provided under arrangements made by the designated hospice; and (2) any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services that are equivalent to hospice care. Payment is not waived for services provided by the individual's attending physician, if that physician is not an employee of the hospice or receiving compensation from the hospice.

The statute provides that an individual, upon making an election to receive hospice coverage, would be deemed to have waived payments for certain other benefits except in "exceptional and unusual circumstances as the Secretary may provide." The regulations do not specify any exceptional or unusual circumstances, because, as supplementary information submitted with the regulations states, HCFA does not yet know of specific types of circumstances that may warrant the use of this exception.

In addition, the statute authorizes the Secretary to establish guidelines to stipulate what services are waived that are related to the treatment of the individual's terminal condition or are the equivalent of hospice care. The proposed regulations do not enumerate the specific services that the Secretary might consider related or equivalent to hospice care. Supplementary information published with the regulations indicates that this has not been done because there are many illnesses which may occur when an individual is terminally ill which are brought on by the underlying condition of the patient. This supplementary information states that it is not unusual for a terminally ill patient to develop pneumonia or some other illness as the result of his or her weakened condition. Treatment of such illnesses would be considered a hospice service and payment of other Medicare benefits would be waived by the hospice election. The supplementary information adds that Medicare fiscal intermediaries and carriers would make determinations in individual cases as to whether the services received are covered hospice services or are among the services waived through the hospice election. Questions arise as to whether the regulations should stipulate, for purposes of uniform and consistent administration, additional examples of which services the Secretary might consider related or equivalent to hospice care and which other kinds of services would not be considered related to terminal conditions.

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