United States General Accounting Office

GAO

Report to the Subcommittee on Health, Committee on Ways and Means, House of Representatives

September 1989

MEDICARE

Program Provisions and Payments Discourage Hospice Participation

GAO/HRD-89-111

GAO
United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-237072

September 29, 1989

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable William D. Gradison, Jr.
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

In response to your request, this report discusses why hospices are not participating in Medicare, the reasonableness of hospice payment rates, and hospice quality requirements. We recommend that the Congress adopt, for all hospices, training and patients' rights provisions similar to those now specified for home health agencies. The report reflects comments from the Department of Health and Human Services and the Hospice Association of America.

We are sending copies of this report to interested congressional committees and subcommittees, the Director of the Office of Management and Budget, the Secretary of Health and Human Services, and other interested parties. It was prepared under the direction of Michael Zimmerman, Senior Associate Director. Other major contributors are listed in appendix VI.

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

When the Congress enacted Medicare hospice benefits in 1982, it was expected that a majority of hospices would join the program. Currently, however, only about 35 percent of hospices participate in Medicare. Because of concern about assuring that all Medicare beneficiaries who elect hospice care can obtain it under the Medicare program, the Subcommittee on Health of the House Committee on Ways and Means asked GAO to determine why hospices are not participating. The Subcommittee also requested that GAO develop information on the reasonableness of payment rates and how quality of hospice care is assured.

Background

Hospices have developed to provide palliative, predominately home-based care for patients with terminal illnesses. Modern hospices also focus on the management of pain and symptoms associated with terminal illness and seek to help patients and families come to terms with death.

Hospice coverage is provided under Medicare for terminally ill beneficiaries who wish to receive palliative care and who are certified by a physician to have a prognosis of 6 months or less to live. Medicare provides for four levels of hospice patient care: routine home care, continuous home care, care provided to give home care-givers a rest (inpatient respite care), and general inpatient care (inpatient care for treatment).

The hospice benefit is administered by the Health Care Financing Administration (HCFA). To qualify to participate in the Medicare program, a hospice must provide a full range of services, develop and implement a plan of care for each patient, and make care available on a 24-hour basis. Medicare uses a prospective payment system, under which hospices receive a fixed daily rate for each level of care. (See pp. 8-11.)

Results in Brief

At least one-half of the nonparticipating hospices sampled during GAO's national survey said the main concerns that led them to choose not to participate in Medicare were (1) the language required in hospices' certification of terminal illness related to the certainty of the physician's prognosis of death, (2) the requirement that hospices obtain contracts with hospitals for inpatient services, (3) limits placed on aggregate payment amounts and inpatient days, and (4) payment rates.

While participating hospices said the certification language was a problem, the majority were not concerned about the limits on aggregate payment amounts or inpatient days nor did they have the same concern with hospital contracts as nonparticipating hospices. Therefore, GAO concludes that the problems nonparticipating hospices have with these provisions may be more perceived than real. (See pp. 17-22.)

Participating hospices stated that the payment rates are a major factor adversely affecting their operations. GAO could not determine the reasonableness of the payment rates because cost data reported by hospices (used in the rate calculation) were inaccurate, inconsistent, and incomplete. A contributing factor to the problems with the cost data was the inadequacy of HCFA's cost report form and related instructions. In addition, the formula used by Medicare to compute unit costs for services—which are the basis for the hospice payment rates—could result in misallocation of overhead costs among the care levels. The reasonableness of hospice payment rates cannot be determined until improvements are made in the accuracy and completeness of cost data provided by the hospices and in the formula HCFA uses to calculate unit costs. (See pp. 25-29.)

GAO Analysis

Medicare Provisions Discourage Hospice Participation

To enroll a patient in a Medicare hospice, hospice physicians must certify that a patient is terminally ill and will die within 6 months. Hospice officials state that physicians favor modification of the certification language to state that the patient is terminally ill and will die within 6 months "if the terminal disease runs its normal course." (See p. 20.)

A participating hospice must have a contract with a facility that provides inpatient care. This contract must stipulate that hospice staff will manage care of the patient at the inpatient facility. Nonparticipating hospices believe physicians at inpatient facilities would be reluctant to relinquish case management to hospice physicians. Participating hospices did not cite physicians' cooperation as a major impediment to obtaining an inpatient care contract but did comment that hospitals are reluctant to contract to provide care for hospice patients at the Medicare hospice inpatient rate. Participating hospices apparently have overcome problems with this provision because all participating hospices included

in GAO's review have been able to either obtain an inpatient services contract or provide all inpatient services in their own facilities. (See pp. 20-21.)

Hospices currently are limited to a total annual aggregate payment of $9,010 times the number of enrolled hospice patients. Nonparticipating hospice officials are concerned that the cap would impose a financial risk for the hospice. Participating hospices did not indicate that the payment cap is a problem. In addition, HCFA data shows no instances in 1984 or 1985 where hospices reached the cap or filed claims that exceeded this cap. (See p. 19.)

Nonparticipating hospices also are concerned that hospices are limited to reimbursement for no more than 20 percent of total care days as inpatient days. Similar to the payment cap, most participating hospices did not consider the inpatient limit to impact hospice operations adversely, and HCFA data shows that most hospices did not reach the 20-percent limit. (See pp. 19-20.)

Reasonableness of Payment Rates Cannot Be Determined

Nonparticipating and participating hospices are concerned that payment rates for the four care levels are too low. GAO could not determine the reasonableness of the payment rates because the data and calculations used to determine the payment rates are flawed.

Cost data reported to HCFA by participating hospices included incomplete and inaccurate data on labor hours and understated overhead costs, parent-organization costs allocated to hospice operations, and inpatient service costs. Contributing to these problems are inadequacies in HCFA's cost report form and instructions. (See pp. 25-28.)

In addition, HCFA's formula for calculating unit costs apportions overhead to cost centers according to square footage—not always an appropriate way to allocate such costs. Another method, such as attributing a share of direct cost to a cost center, may be more appropriate. (See pp. 28-29.)

Medicare Has Appropriate Quality Care Requirements

The Medicare program incorporates appropriate quality assurance standards used by other licensing and certification organizations. Home visits conducted by state officials can be a reasonable way to ensure that quality care is provided. (See pp. 32-35.)

Medicare requires home health agencies to train employees and protect patient rights. These requirements, which apply only to hospices affiliated with home health agencies, are not imposed on other hospices. Making the requirements applicable to all hospices could help ensure that hospice patients receive quality care. (See p. 36.)

Recommendations

To ensure that quality of hospice care is maintained, GAO recommends that the Congress amend the Medicare law to adopt, for the hospice program, the home health aide training and patients' rights provisions contained in the Omnibus Budget Reconciliation Act of 1987. (See p. 37.)

To make Medicare's hospice benefit more attractive to qualified hospices, GAO recommends that the Secretary of Health and Human Services direct the Administrator of HCFA to amend the language in the hospice certification of terminal illness to add "if the terminal illness runs its normal course." (See p. 24.)

GAO also is making a number of recommendations to HHS to improve the accuracy and completeness of the cost data reported by hospices and HCFA's unit cost calculations. (See pp. 29-30.)

Agency Comments

HHS stated that a study done for HCFA supports GAO's findings as to why hospices do not participate in Medicare, and HHS agreed with GAO's finding that problems exist with the hospice cost data. Additionally, HHS agreed that all home visits and their results should be reported to HCFA and that audits of hospice cost reports would help provide more complete and accurate data.

However, HHS disagreed with some of GAO's suggestions for improving cost data and changing the language in the physician's terminal illness certificate. GAO continues to believe that action on these recommendations should be implemented because such action could result in expanded hospice participation in Medicare and should not adversely affect the program's cost.

The Hospice Association of America agreed with the contents of the report. The National Hospice Organization also was asked to review a draft of this report, but did not provide comments.

Contents

Appendixes

Tables

Abbreviations

COBRA	Consolidated Omnibus Budget Reconciliation Act
HAA	Hospice Association of America
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
JCAHO	Joint Commission on the Accreditation of Health Care Organizations
NHO	National Hospice Organization
OBRA-87	Omnibus Budget Reconciliation Act of 1987
TEFRA	Tax Equity and Fiscal Responsibility Act

Introduction

The modern concept of hospice developed as a means of providing care to the dying that takes their unique needs into account.[1] In addition to the nursing care, spiritual and emotional support, and home care that characterized early European hospices, modern U.S. hospices focus on the management of pain and symptoms associated with terminal illness and seek to help the patient and family cope with death.

Hospice benefits became a permanent feature of the Medicare program in 1985, following a demonstration program that started in 1980 and continued for several years. But subsequently, quite a few hospices decided not to participate in Medicare, and concern arose as to whether all Medicare beneficiaries could obtain quality care under the Medicare hospice program.

Accordingly, the Subcommittee on Health of the House Committee on Ways and Means asked us to determine (1) what factors influence a hospice's decision not to participate in Medicare, (2) the reasonableness of payment rates set for hospice care, (3) any additional standards the Congress could adopt to assure quality patient care in participating hospices, and (4) whether the administration of the hospice benefit has been consistent with Medicare policy.

Hospice Care Nontraditional

Hospice care is recognized as an alternative way of caring for the terminally ill that differs from traditional medical care in several respects:

- Hospice care is palliative, directed toward maintaining the functional abilities of the patient and controlling pain, rather than curative.
- The family is involved and supportive in caring for the patient.
- Hospice programs usually emphasize home care. Inpatient facilities, hospitals, or nursing homes are used when necessary to provide acute or respite care.
- The emotional needs of the terminally ill and their families are given as much attention as the medical needs of the patient.
- A portion of administrative and patient care services are provided by hospice volunteers.

Five basic hospice organizational models have evolved: hospital-based, nursing home-based, home health agency-based, freestanding, and community-based (a coalition of volunteer groups).

[1] A brief history of the hospice movement is contained in Hospice Care—A Growing Concept in the United States (HRD-79-50), Mar. 6, 1979.

History of Medicare's Hospice Benefit

Title XVIII of the Social Security Act makes available a broad health insurance program, known as Medicare, to most elderly age 65 and over and certain disabled people. Medicare, which is administered by the Health Care Financing Administration (HCFA), provides two insurance programs for the aged and disabled: hospital insurance (part A) and supplemental medical insurance (part B).

Hospital insurance is primarily financed by social security taxes. Supplemental medical insurance, a voluntary program, is financed by general tax funds and monthly premiums collected from beneficiaries.

In 1980, HCFA initiated a demonstration project with 14 hospital-based, 9 home health agency-based, and 3 freestanding hospices. Reimbursement was permitted for all hospice services provided to Medicare and Medicaid[2] beneficiaries. The project was designed to help the Department of Health and Human Services (HHS) evaluate the levels of hospice care, the range of services they furnish, and costs of these services. In doing so, it was to give HHS a basis for developing standards and making policy decisions regarding Medicare and Medicaid coverage of hospice services.

Originally, the project was intended to end in October 1982, but the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (P.L. 97-248) authorized Medicare hospice benefits on a trial basis. The Congress included a provision in the TEFRA legislation to terminate the benefit, effective October 1, 1986, unless the Congress acted to provide an extension. The hospice benefit was made permanent by a provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (P.L. 99-272).

TEFRA provided that initial hospice reimbursement be based on reasonable costs, up to a cap amount. It also directed that the Secretary study the feasibility and advisability of providing prospective reimbursement. However, when final implementing regulations were published by HCFA in 1983, they provided for a prospective payment system based on cost data obtained primarily from the hospice demonstration project.

[2]Medicaid, established by title XIX of the Social Security Act, provides payment through state agencies for the costs of covered medical services for low-income people.

Services Covered Under the Hospice Benefit

Medicare covers hospice care for terminally ill beneficiaries who wish to receive such care and are certified by a physician to have a prognosis of 6 months or less to live. Beneficiaries electing hospice care waive all nonhospice Medicare benefits for care related to the terminal illness except for services provided by an attending physician. Under the benefit's initial provisions, beneficiaries were entitled to 210 days of hospice care. The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) removed the day limitation.

For a facility or organization to qualify as a hospice, Medicare requires that certain core services must be provided. These include nursing care, medical social services, physician services, and counseling services (including bereavement counseling for the family after the patient dies). In addition, hospices must directly or through contractual arrangements provide physical, occupational, and speech therapy, and home health aide and homemaker services. These requirements were designed to ensure that hospices maintain a staff of health professionals capable of providing the usual hospice services while giving them the flexibility to provide certain less frequently needed services on a contractual basis. Examples of the latter are speech therapy or the use of a temporary nurse if the hospice experiences an unusually high case load.

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

Included in the hospice benefit are family counseling concerning care of the terminally ill individual and patient counseling to assist in adjusting to death. Short-term inpatient care also can be provided, when necessary, for pain and symptom control. Inpatient care to provide a respite for family care givers is likewise allowed. However, hospices must maintain professional management of their patients during inpatient stays to ensure that the patient's plan of palliative care is carried out.

Medicare Payment for Hospice Services

HCFA established base per diem rates to pay hospices prospectively for services rendered in each of four categories of care. The Congress required the Secretary of HHS to adjust the rates annually, beginning in 1985, basing them on the reasonable cost of hospice care and services. The categories and current base rates are:

- Routine home care ($63.17 per day) includes all care provided at the patient's home that is not considered continuous home care. Hospices receive this amount for every day a patient is enrolled with them regardless of whether any services are furnished on a given day.
- Continuous home care ($15.36 per hour up to $368.67 per day) is provided by a nurse, home health aide, or homemaker on a continuous basis during periods of crisis.
- General inpatient care ($281 per day) is provided at an inpatient facility for pain control or symptom management.
- Inpatient respite care ($65.33 per day) is provided in a approved facility, such as a hospital, for a short period so that the family of the patient can have a respite.

These four base rates vary geographically because they are adjusted by HCFA to reflect differences in area wage levels.

Two payment limits were designed to control Medicare financial risk and guard against overutilization of hospice services. First, a hospice's total annual Medicare payment cannot exceed an aggregate limit. This is calculated by multiplying the cap amount per beneficiary—currently $9,010, but adjusted annually for increases or decreases in medical care expenditures—by the number of beneficiaries served by the hospice during the period. This cap is designed to ensure that total payments for hospice care do not exceed the amount that would have been spent by Medicare had the patient been treated in a conventional setting.

In addition, hospices cannot be paid for inpatient days—including inpatient respite days—beyond 20 percent of the total days for which the patients had elected hospice care. This limitation was included to keep the benefit consistent with the concept of hospice as primarily home-based care.

Another requirement placed on hospices by Medicare is that they must utilize volunteers in their provision of care and services. Volunteers traditionally have played an important role in hospice care and in keeping the cost of hospice care down. By regulation, the standard for volunteer participation has been set at 5 percent of total patient care hours.

HCFA Hospice Studies

The legislation establishing the hospice benefit required the Secretary of HHS to conduct two studies.

The first study essentially was an evaluation of the costs and quality of care of hospices involved in the demonstration project. A report on this study, made by Brown University, was issued in 1983.

A second study requirement provided for the Secretary of HHS to report to the Congress on the fairness, equity, and efficiency of the hospice provisions. It was to include, among other things, an examination of the feasibility and advisability of developing and providing for prospective reimbursement of hospice care. Although the study was not completed, HCFA implemented a prospective payment system shortly after the study was mandated. Public Law 98-617 then required HCFA to review annually and appropriately adjust the payment rates for hospice services, and report to the Congress on the adequacy of the rates to ensure participation by an adequate number of hospices. In its report on the bill that became Public Law 98-617, which was enacted without material changes, the House Committee on Ways and Means expressed concern that insufficient data were used to set the original rates and that not enough hospices were becoming Medicare-certified. The first report, which was due in October 1986, has been delayed, according to HCFA, because of inadequate data.

A study conducted by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) examined the appropriateness of specific Medicare hospice provisions. A report on the study, completed in March 1987, contained information on differences between certified and uncertified hospices and the quality of care provided. On average, the study found, certified hospices were larger, provided more comprehensive services, and provided care with more professional and appropriately trained staff than hospices not certified.

TEFRA required the Secretary of HHS to report, with respect to hospice demonstration projects, on the appropriateness of hospice reimbursement levels, caps, and payment limitations. In 1987, as part of this study, HCFA twice asked its claims payment contractors—referred to as intermediaries—to review hospice cost reports to validate hospice prospective payment rates. The first effort included cost reports of hospices with a full 12-month reporting period whose fiscal year ended during calendar year 1986. This effort yielded 198 cost reports. About 63 percent of those cost reports were deemed unusable by HCFA for validating payment rates because of significant discrepancies or errors.

In the second effort, in August 1987, HCFA again asked its intermediaries to perform similar reviews of hospice provider cost reports with fiscal

years ending between July 1, 1986 and June 30, 1987. Six months of this selected period overlapped the prior year's effort and thus constituted a second review opportunity for some cost reports. From this effort, HCFA used cost data from 237 hospices. However, cost data for about 40 percent of these hospices contained errors and HCFA eventually decided to use only those cost reports containing data it judged acceptable.

Objectives, Scope, and Methodology

Because the Chairman and Ranking Minority Member of the Subcommittee on Health, House Committee on Ways and Means, were concerned about ensuring that all Medicare beneficiaries who elect hospice care can obtain quality care under the Medicare program, they asked us to determine

- the factors that influence a hospice not to participate in the Medicare hospice benefit;
- whether prospective payment rates set by HCFA for hospice care are reasonable;
- whether there are additional standards the Congress could adopt to assure that participating hospices provide quality care; and
- whether the administration of the hospice benefit by HCFA and its intermediaries has been consistent with program policies.

Questionnaire Used in Survey

From various industry sources, we synthesized a list of 1,946 organizations believed to be hospices that were not Medicare-certified. From this list, we selected a random sample of 710 such organizations and sent them questionnaires. During the course of our work, we discovered that many of these organizations were not hospices, reducing our estimate of the total number of hospices that were not Medicare-certified to about 1,290. (See app. I.)

The questionnaires were designed to determine why hospices that appeared to qualify for the Medicare program decided not to participate; what program provisions, if any, influenced that decision; and how those provisions could be changed to make hospices consider applying for certification in the program. We received responses to this questionnaire from 308 hospices, a response rate of about 61 percent of those sent to nonparticipating hospices.

In addition, we sent a questionnaire to all 423 hospices that were participating in Medicare in November 1987. The responses received from 320 participating hospices (a response rate of about 76 percent) provided us

with data on hospice experiences under Medicare and concerns hospices have about certain Medicare benefit provisions and whether they adversely affect hospice operations. A summary of the responses to our questionnaires will be sent upon request.

Visits, Interviews Contributed to Analysis

We visited nine hospices (three hospital-based, three home health agency-based, and three freestanding) and reviewed their Medicare cost reports. To evaluate HCFA's basis for setting prospective payment rates, we also analyzed the 121 cost reports from 1986 and 1987 that HCFA judged most usable for rate validation purposes. The 121 reports were submitted by 26 freestanding hospices, 80 home health agency-based hospices, and 15 hospital-based hospices. Because of the small number of Medicare-certified, skilled nursing facility-based hospices (only 9 of the 1,946 hospices on our synthesized list), we excluded them from our cost analyses.

To assess the administrative and management functions of the program, we performed certain other on-site reviews. We visited (1) the offices of eight Medicare intermediaries; (2) HCFA's Philadelphia, Atlanta, and San Francisco Regional Offices; (3) HCFA headquarters in Baltimore, MD.; and (4) nine state offices that conduct surveys and certify hospices for the Medicare program.

Also, we conducted telephone interviews with survey and certification officials in all 50 states, Puerto Rico, and Washington, D.C., and with JCAHO. Our purpose was to determine whether (1) Medicare hospice standards can ensure that participating hospices are capable of providing quality patient care and (2) there are additional standards the Congress could adopt to assure that hospices participating in the Medicare hospice benefit are providing quality patient care.

To obtain the views of hospice trade organizations, we interviewed officials at the National Hospice Organization (NHO) and the Hospice Association of America (HAA). We queried them on issues related to benefit provisions and the content of our survey questionnaires. In addition, we interviewed officials at Abt Associates and the Joint Commission on Accreditation of Health Care Organizations—contractors doing hospice studies for HCFA—to gain insight into issues common to our study.

We gave HHS, NHO, and HHA the opportunity to review a draft of this report. HHS and the Hospice Association of America provided comments on contents of the draft reports. (See apps. 4 and 5.)

Our work was conducted during the period February 1987-March 1989 in accordance with generally accepted government auditing standards.

What Can Be Done to Increase the Number of Hospices Participating in Medicare?

Of an estimated 1,700 hospices in the United States in 1989, about one-third (some 35 percent) participate in the Medicare program, our survey indicated. Both participating and nonparticipating hospices had some concerns about the program. Many hospices did not apply for Medicare certification, they said, because of the program's payment levels, the requirement that physicians certify that a patient's illness will result in death within a 6-month period, or the hospice's ability to obtain the required contract for inpatient services. Hospices that did participate in Medicare cited several factors adversely affecting hospice finances, patient load, or quality of care. These factors included unreimbursed costs for bereavement counseling to family members to help them adjust to the patient's death and the program requirement that a physician provide a terminal prognosis within two days of patient admission. The claims processing and payment system did not appear to be a factor in a hospice's decision to participate in Medicare, and participating hospices generally appear satisfied with intermediaries' claims processing.

Generally, hospice officials favored changing the basis for hospice payments to a cost reimbursement system and changing or eliminating the above-mentioned requirements that caused them concern.

Hospice Participation in Medicare

Since the early 1980s, the U.S. hospice industry has grown substantially. From 1983 to 1989, we estimate the total number of U.S hospices grew from 516 to more than 1,700. From the beginning of the Medicare hospice benefit program through February 1989, the number of certified hospices grew from 30 to 609. Medicare hospice outlays for 1984 totaled about $2.8 million. By 1987, the latest data available, outlays had increased to about $176 million. In addition, some hospices receive support from charitable organizations and payments by patients and private health insurance policies.

Not all of the approximately 1,100 hospices currently not participating in Medicare could qualify for Medicare certification. From answers to specific questions included in our questionnaire, we determined that about 75 percent of responding hospices are structured like the Medicare model, provide services consistent with Medicare standards, and would have a reasonable expectation of meeting Medicare certification requirements. Projecting this percentage to the approximately 1,100 nonparticipating hospices indicates that about 830 nonparticipating hospices might be able to obtain Medicare certification. The methodology we used to identify qualified hospices is discussed in more detail in appendix II.

Because a nonparticipating hospice may be qualified for Medicare certification does not necessarily mean that it would seek certification. Twenty-nine hospices, about 13 percent of qualified, nonparticipating hospices that responded to our questionnaire, indicated that they would not seek Medicare certification. The majority saw no need to be certified. However, a few hospices were more specific, indicating that services can be provided best in coordination with other health care organizations in their community rather than through Medicare-certified hospices such as coalition models. Others, citing certification as a low priority because of their location in areas of small population, chose to focus on community-based care.

In addition, 42 hospices, about 18 percent of qualified, nonparticipating respondents, indicated that they were small or rural hospices and that Medicare certification was not feasible. Medicare's direct service requirement and the reimbursement rates were among the reasons cited for nonfeasibility.

Seventy-one hospices that told us it was not feasible to participate said they would not seek Medicare certification. From these results, we estimate that there are approximately 574 nonparticipating hospices across the country that could participate in Medicare.

Why Qualified Hospices Are Not Applying for Certification in Greater Numbers

Three Medicare benefit provisions were cited as significant problems by both participating and nonparticipating hospices we queried. These were (1) the payment levels, (2) the language included in the physician's certification, and (3) the requirement to contract for inpatient services. Two provisions—the $9,010 per enrollee payment cap and the 20-percent inpatient day limit—were not as serious concerns to participating hospices as to nonparticipating hospices.

Our questionnaire covered a number of Medicare benefit provisions that hospice and hospice organization officials told us could be of concern to hospice officials. In addition, we asked those officials to list any others they perceived as problems. Overall, they identified 27 provisions. We ranked the provisions according to the number of responding hospice officials indicating at least moderate concern with them (see app. III). The top eight provisions of concern to nonparticipating hospice officials and their responses are shown in table 2.1 along with the corresponding responses from participating hospices.

Table 2.1: Benefit Provisions of Most Concern to Hospice Officials[a]

	Nonparticipating concerned		Participating concerned	
Medicare provisions	**Percent**	**Rank**	**Percent**	**Rank**
General inpatient care rate	66	1	83	1
Routine home care rate	62	2	81	2
Inpatient respite care rate	58	3	70	7
$9,010 aggregate cap	57	4	33	14
Continuous home care rate	55	5	72	6
Doctor's certification of terminal illness	54	6	72	5
20-percent inpatient day limit	49	7	27	19
Inpatient services contract	49	8	62	9

[a]The 210-day lifetime benefit limit was among the top-ranked concerns of both certified and uncertified hospices. However, this should no longer be a concern because the Medicare Catastrophic Coverage Act of 1988 provided an additional indefinite benefit period after the basic 210-day period has expired, subject to recertification of terminal illness.

In this chapter, we discuss the Medicare hospice provisions of most concern to officials from qualified nonparticipating and participating hospices. Each section includes a discussion of the provision, hospice comments on the provision, and program changes most frequently suggested by hospice officials. The officials said that these program changes would prompt them to reconsider applying for Medicare certification or would help improve participating hospices' operations.

Payment Rates

Hospices participating in the Medicare program are paid predetermined rates for services rendered in four categories of care. Qualified hospices not participating in the program perceive the Medicare payment rates to be a problem and a major factor in deciding not to apply for Medicare certification. Participating hospice officials also view the prospective rates as a major factor adversely affecting hospice operations. Most concern is focused on the routine care rate and the general inpatient rate, which account for 96 percent of hospice revenues.

Hospice officials most frequently suggested changing the payment method to a cost reimbursement system as a way to improve hospice operations and/or influence hospices to consider applying for Medicare certification.

In addition, hospice officials often suggested increasing the payment rate for inpatient care, calling it inadequate for patients needing expensive palliative care. For example, hospice patients with cancer may be provided with X-ray or chemical treatments—not to cure the disease,

but to reduce the size of the tumor, thereby relieving pressure and pain to other internal organs.

Another suggestion was that HCFA allow hospital claims to be filed under regular Medicare part A benefits regardless of the reason for admission. Because Medicare would directly pay the hospital, this would eliminate the need for hospices to negotiate inpatient rates with hospitals. Such a change would be a significant departure, however, from the Medicare requirement that hospices be responsible for all care, and the costs of it, related to the patients' terminal illness.[1]

Aggregate Cap of $9,010

The maximum annual amount a hospice can receive from Medicare is $9,010[2] times the number of beneficiaries served during a year. Nonparticipating hospice officials indicated concern over the financial risk posed by the $9,010 cap. Certified hospices expressed similar concern but to a lesser degree. Hospice officials most frequently suggested that the limit should be eliminated.

The relative lack of concern by certified hospice officials seems to indicate that the cap is not a significant problem. On average, patients spend about 30 days in a hospice program. Further, data provided by HCFA spanning 2 years of hospice operations (in 1984 and 1985) showed that none of the hospices in the study filed claims for more than the cap. However, under new legislation allowing for an indefinite patient benefit period,[3] the cap could become a more important payment limitation. This might occur if patients are brought into the hospice at an earlier stage of their illness or there are increases in the lengths of stay.

Inpatient Care Limited to 20 Percent of Total Care

A hospice cannot be reimbursed for inpatient days beyond 20 percent of its total days of care. This limit was legislatively imposed to ensure that hospice care is home-oriented and that home care is furnished rather

[1]Chapter 3 of this report discusses hospice reimbursement rates in detail and problems we encountered in trying to determine the reasonableness of the established rates.

[2]HCFA is required to adjust this cap annually. $9,010 is the cap in effect from November 1, 1988 through October 31, 1989.

[3]The Medicare Catastrophic Coverage Act of 1988, most of which took effect on January 1, 1989, provides for an additional indefinite benefit period after the basic 210-day period has expired. To qualify for the extension, a patient's 6-month terminal prognosis must be recertified by a physician.

than generally more costly hospital care. This provision is of major concern to nonparticipating hospice officials but is of less concern to certified hospices. Uncertified hospice officials called the 20-percent limit unrealistic, saying it could contribute to hospice financial instability and prevents many terminally ill patients without supportive family to provide in-home care from utilizing hospice services. Officials from uncertified hospices most frequently suggested that the limit be eliminated.

The relatively low level of concern by officials from certified hospices about the 20-percent limit indicates the limit is not a significant problem. Acute inpatient care accounts for only about 4 percent of total hospice days of care, our analysis of hospice cost reports revealed. HCFA data from the 2-year study showed inpatient care provided by most hospices to be well below the 20-percent limit.

Physician Certification of 6 Months' Terminal Prognosis

To admit a patient, Medicare hospices must obtain a physician-certified prognosis of terminal illness. The hospice medical director or the physician member of the interdisciplinary group and the patient's attending physician (if the patient has one) must state in writing that the individual has a life expectancy of 6 months or less. This requirement is designed to ensure that the patient's condition has been assessed at or before admission to a hospice program. In addition, proper and timely assessment of a patient's condition is of critical importance to both the hospice, which becomes responsible for the patient's care, and the patient, who must have a sound basis for choosing palliative rather than curative care.

This issue is high on the list of concerns of both certified and uncertified hospice officials because of the uncertainty involved in such a long-term prognosis. Responding officials most frequently suggested that the doctor's written certification include a clarifying statement, "The patient is terminally ill and will die within 6 months if the terminal disease runs its normal course." Adding this clause would not significantly change the meaning of the doctor's certification but would clarify the meaning to the physicians involved, hospice officials, and the patient.

Professional Case Management/Inpatient Services Contract

A hospice is required to have a contract with a facility that provides inpatient care for the hospice's patients. This contract must be a legally binding written agreement stipulating that the hospice staff will maintain professional management of the patient while he or she is receiving inpatient care.

This requirement concerns both participating and nonparticipating hospices. Nonparticipating hospice officials commented that physicians at inpatient facilities will not relinquish case management to hospice physicians. Participating hospice officials cited a different concern, that hospitals will not contract at the Medicare hospice inpatient rate of $281 per day. Many hospice officials suggested that the provision be eliminated. However, the nonparticipating hospice concern does not appear to be supported by hospices' experience in the program. If problems do exist, they apparently can be overcome. All certified hospices we reviewed either had inpatient services contracts or provided inpatient services in their own facilities.

Concerns of Participating Hospices

Participating hospices expressed concerns about two program provisions that nonparticipating hospice officials did not perceive as problem areas—a 2-day limit to obtain a physician's terminal illness certification and unreimbursed bereavement counseling.

Hospices are required to obtain the certification of a physician within 2 days after admission of a patient to a hospice. The 2-day limit was implemented to establish the hospice's responsibility for the care of the patient and to provide the patient with a sound basis for choosing palliative rather than curative care. Intermediaries interpret and apply the 2-day rule in the following way. If a hospice fails to obtain the necessary certification within the 2-day grace period, it is subject to denial of payment for all days of service from the day of admission to the date of certification, including the first 2 days.

Of the 78 percent of participating hospices that cited the 2-day limit as a problem, over 80 percent said they believed the limit should be changed to 8 days.

Bereavement counseling represents a significant cost to some hospices, our survey showed. Hospices are required to provide such counseling to family members to help them adjust to the patient's death. The costs for these services are not reimbursable and HCFA does not consider them when setting prospective rates for hospices. This exclusion exists because enrollment of the Medicare beneficiary in the hospice is the basis for service eligibility and enrollment ceases with the patient's death. Of the certified hospice officials we queried, 76 percent think the exclusion of Medicare payment for bereavement counseling after the patient's death adversely affects hospice operations. Six percent said that bereavement counseling should not be a requirement.

Officials from 218 participating hospices reported that they provided, on average, 183 bereavement contacts for families of Medicare patients during 1986. The average total bereavement counseling cost reported by these hospices for that year was about $6,000, ranging from no cost (possibly representing volunteer work) to nearly $60,000. According to the JCAHO study of hospices, 71 percent of all hospices in 1986 had annual budgets of less than $150,000. Therefore, it appears that bereavement costs may represent approximately 4 percent of total hospice costs for most hospices.

Effect of Intermediaries on Hospice Decisions to Participate in Medicare

Intermediary performance was not identified by our respondants as a factor that affected hospices' decisions to participate in Medicare. (Intermediaries are organizations under contract to HCFA that are responsible for processing provider claims and either paying or denying those claims.) In addition, HCFA data on intermediaries' performance shows that payments are generally made to hospices within time limits established by HCFA.

HCFA's Contractor Performance Evaluation Program establishes specific time limits for intermediary processing of hospice claims. In fiscal year 1987, the time limits were:

- 95 percent of "clean" claims[4] had to be paid within 30 days,
- 95 percent of all claims had to be paid within 60 days, and
- 99 percent of all claims had to be paid within 90 days.

In the aggregate, intermediaries met all three time limits for hospice claims processed between February 1987 and September 1987, according to published HCFA reports. Of the 10 designated regional intermediaries, 6 met or exceeded all three time limits and only 1 failed to meet all three (see table 2.2). When time limits were missed, they were usually missed by a small amount and/or subsequent time limits were met.

[4]Claims that did not require additional documentation from the provider for the intermediary to determine appropriateness of payment.

Table 2.2: Intermediary Claims Processing Timeliness Data for Hospice Claims (Feb.-Sept. 1987)

	Clean claims		All claims		
		Percent processed in 30		Percent processed in	
Intermediary	Total	days	Total	60 days	90 days
All intermediaries	62,014	98.3	68,267	98.8	99.6
B/C-Maine	467	100.0	480	100.0	100.0
Prudential-N.J.	34,922	99.2	37,325	99.5	99.8
B/C-Greater Phila.	750	98.7	773	99.6	100.0
Aetna-Florida	902	91.7[a]	1,036	91.9[a]	99.1
B/C-S.Carolina	563	93.1[a]	789	90.9[a]	97.7[a]
B/C-Illinois	1,620	98.3	1,629	99.6	99.8
B/C-Wisconsin	2,215	100.0	2,115	100.0	100.0
B/C-New Mexico	834	88.7[a]	1,075	99.8	99.9
B/C-Iowa	3,598	93.2[a]	3,821	95.4	97.5[a]
B/C-California	4,956	100.0	5,632	99.2	99.9

[a]Less than HCFA evaluation standard

Conclusions

Many hospices are not participating in Medicare, our questionnaire revealed, because of reservations concerning the adequacy of payment rates, the cap on total payments to a hospice, the 20-percent limit on inpatient care, the requirement for inpatient services contracts, and the language contained in the certification of a patient's terminal illness.

The concerns with the cap on total hospice payments and the limit on inpatient care days appear to be based more on individuals' perceptions rather than the existence of real problems. Hospices participating in Medicare usually did not cite these provisions as problems, and we could find no instance where hospices had filed claims for services that exceeded the cap or limit. The caps and limits may become more important in the future, however, because the Medicare hospice benefit has been extended beyond 210 days.

Nonparticipating hospices' concerns related to certifying patients' terminal illnesses were shared by participating hospices and, judging by questionnaire responses, changes to this provision may induce more hospices to participate in Medicare. A clarifying change in the certification language should not adversely affect the program and could help gain additional participation by hospices.

Recommendation to the Secretary of HHS

We recommend that the Secretary of HHS direct the Administrator of HCFA to change the wording in the Medicare regulations regarding the physician's certification of terminal illness to include the clarifying statement that the individual's medical prognosis is that his or her life expectancy is 6 months or less "if the terminal illness runs its normal course".

Agency Comments and Our Evaluation

HHS commented that it does not believe it necessary to modify the wording of the required physician certification as we recommended, because the current wording implicitly includes the suggested addition. As we pointed out on page 20, adding to the certification the phrase "if the terminal illness runs its normal course" would not significantly change the meaning of the current wording but would clarify the meaning for physicians. The certification language was a major concern of both certified and noncertified hospices. Addition of such language would have no ill effect on the program and might induce additional hospices to participate in Medicare. Therefore, we believe the suggested modification should be made.

HHS also said that a HCFA-sponsored study of the reasons for hospices not participating in Medicare produced results similar to ours.

Reasonableness of Hospice Payment Rates Cannot Be Determined From Available Cost Information

A major objective of this review was to evaluate the reasonableness of Medicare's prospective payment rates for hospices. We could not do so because the cost data reported to HCFA by hospices and used by HCFA to calculate payment rates is incomplete, inconsistent, and inaccurate. As a result, some reported costs were too high, some too low, and some could not be determined. In addition, the formula that HCFA uses to apportion overhead costs incurred by hospices and/or their parent health agencies or hospitals may be inadequate or inappropriate for this purpose.

In calculating hospice payment rates, HCFA apportions cost data to various hospice activities to arrive at unit costs for each care level. HCFA's formula for doing so primarily uses data from its hospice cost report form. The accuracy of rates resulting from HCFA's formula depends on the quality of the data used in the formula and the appropriateness of the formula. The remainder of this chapter discusses problems with these two factors.

Errors in Hospice Cost Data

Some cost data supplied by the hospices were inaccurate and/or incomplete, our analysis of 121 hospice cost reports that HCFA judged to be most usable for rate validation purposes indicated. Errors existed in time charges and costs for visiting services such as nursing and home health aide services, and certain overhead costs were not included. In addition, unit costs computed for hospital-based hospices were understated because the reports often lacked the costs of ancillary services provided to hospice patients by the parent hospitals. Finally, inpatient service costs may be understated because hospices do not report the costs of all contracted inpatient care incurred but not paid during the year.

Accounting for Paid Labor Hours Incomplete and Inaccurate

HCFA uses paid labor hours, reported on the hospice cost reports, to apportion costs to the proper care category. Of the 121 hospice cost reports we reviewed, 17 were inaccurate because $216,150 of visiting service costs[1] were not allocated to care categories. This occurred because no labor hours were reported for these costs.

In addition, the paid labor data reported on some of the hospice cost reports reflected widely varying hourly rates. For example, the reported average direct nursing service costs generally ranged from a low of

[1]About 1.5 percent of total visit costs reported on the 121 hospice cost reports.

about $1 per hour to a high of about $40 per hour. We believe two factors contributed to the wide disparity in the computed hourly wage rates—hospice data compilation errors and varying interpretations of HCFA's guidelines about which hours should be accumulated and reported.

Data accumulation errors appeared to be due, in large part, to hospice accounting systems that did not capture the data necessary to prepare accurate cost reports. Eighty-nine percent of questionnaire respondents reported that hospice data collection systems and HCFA cost-reporting requirements were incompatible and presented cost-reporting problems.

Our audits at nine hospices found numerous tabulation and mathematical errors in the cost reports, even though the cost report data had been checked by the intermediary. For example, at seven of the nine hospices, we found differences between the cost report data and available supporting records and schedules for the number of hours of paid labor, the major cost item for hospices. The differences ranged from an overstatement of 3 percent to an understatement of 210 percent in the total hours of paid labor. On average, the seven hospices understated total hours of paid labor by 9.4 percent.

At one of the two remaining hospices, supporting records were not available to validate reported paid labor data. The ninth hospice resubmitted its cost report and correctly reported total paid labor hours.

Varying interpretations by hospices of the paid hours that should be tracked and reported also appeared to contribute to the discrepancies in the hourly wage rates. Some hospices interpreted HCFA's instructions to require reporting of only the time visiting service personnel spend face-to-face with patients. Other hospices included face-to-face time with patients plus travel time, while a third group included face-to-face time with patients, travel time, and patient medical record charting time. Still others apparently report all paid hours of visiting services staff. The differences in interpretation of HCFA's instructions result in the use of inconsistent and incomplete paid labor data in HCFA's unit cost calculation.

Overhead Costs of Hospital- and Home Health Agency-Based Hospices Understated

The formula HCFA uses to compute unit costs for hospices includes a factor for apportioning parent organizations' administrative and general overhead costs. However, as the hospice cost report contains no place to record these costs, they must be obtained from the parents' cost reports. In many cases, however, these costs were not used in calculating unit costs. For example, we found that for four hospices we visited, the parent's Medicare cost report included $650,000 of administrative and general overhead costs associated with hospices' activities. However, only $526 of those costs were used in HCFA's unit cost calculation and, therefore, HCFA's calculation understated hospice unit costs.

Cost Reports in HCFA's Data Base Understate Costs of Hospital-Shared Services

Hospital-based hospices often obtain inpatient services for their patients from the parent hospital, but typically the hospices did not include in their cost reports all costs associated with the inpatient stay. Thus, hospice costs used by HCFA to compute the inpatient rate generally were understated.

Of the 15 hospital-based hospice cost reports we reviewed, 5 included no data for inpatient services. The remaining 10 hospices reported a total of 3,940 days of inpatient care but only 1 reported any data related to ancillary services, such as drugs and therapy. Moreover, this hospice did not include the data necessary for HCFA to determine the costs of the ancillary services. As a result of these incomplete data, HCFA's computation of the inpatient hospice rate included no costs for 5 of the 15 hospices and no ancillary service costs for the other 10.

Our detailed audit at one of the nine hospices not reporting ancillary service charges illustrates the effect that omitting these data can have on reported inpatient costs. Patients in this hospice were provided 207 days of inpatient care in the parent hospital. From hospital records, we determined that the parent hospital furnished inpatient ancillary services with charges totaling $17,942. Converting these charges into costs and factoring the costs into the unit cost calculation increased the general inpatient unit cost from $185.77 to $255.91.

Cost Reports Understate Contract Inpatient Service Costs

Contract inpatient service costs for two of the nine hospices we audited were understated because the hospices had not paid for some of the inpatient services at the end of the year. Nor had they accrued the payment liability in their accounting records, as called for by HCFA's guidelines. Understating inpatient costs reported to HCFA has the effect of understating the HCFA-calculated unit costs.

One of the freestanding hospices we audited had entered into agreements with several area hospitals for the provision of general inpatient care services when such care was required for their hospice patients. According to the hospice cost report, 666 general inpatient days of care were provided. Total costs claimed were $119,355. The average daily unit cost was $179, less than the lowest of the negotiated contract rates and less than the Medicare inpatient payment rate.

The hospice had not been billed for many of the inpatient days, pertinent patient and accounting records showed, and had recorded no liability in its accounting records reflecting any payment obligation.[2] From invoices, we estimated the average daily cost of inpatient services at $337. Thus, the general inpatient unit cost rate was understated by $158 per day.

As our review included only the cost report from 1986, we did not determine what accounting method was used in prior or subsequent years. If this hospice was consistent from year to year in reporting inpatient costs when paid for rather than when the service was incurred, the effect on unit costs may be balanced over several years. However, there is no assurance that this will occur and costs may be overstated or understated in subsequent years.

Problem With HCFA's Unit Cost Formula

The cost report forms developed by HCFA contain 22 to 25 patient care cost centers (depending on hospice type), in which direct costs incurred by hospices are reported. HCFA's unit cost formula apportions overhead costs incurred by the hospice and/or by the parent home health agency or hospital according to the square footage of floor space used by the direct patient care cost centers.[3] But in some cases, floor space provides an inadequate or inappropriate method to apportion overhead costs.

Many hospices do not report square footage for direct care cost centers. In addition, because of the emphasis on home care, hospices generally

[2]Because of the absence of billing records for many hospice patients, we contacted the Medicare intermediary that served the hospitals in which the inpatient services were obtained. We determined that many of the inpatient services were erroneously billed as regular Medicare inpatient services. Therefore, the hospice was paid by its intermediary for the inpatient services and the hospitals were paid by their intermediary for the same inpatient services. The hospital intermediary is currently making efforts to recover the duplicate payments.

[3]For Medicare cost-reporting purposes, a cost center is an organizational unit, such as a department, that has a common functional purpose, and for which direct and indirect costs are accumulated, allocated, and apportioned. A cost center also may include certain expense classifications, such as depreciation.

have small physical size and the amount of floor space used does not necessarily reflect anything in particular about hospice costs. These characteristics are particularly typical of home health agencies, making the apportionment of parent home health agency overhead costs using square footage virtually useless.

Of the 121 hospice cost reports we reviewed, 41 reported no square footage for any of the direct patient care cost centers. For these hospices, a HCFA official searched the hospice cost reports and other documents. In some cases, he told us, he found that the hospices had provided their own apportionment of overhead costs to cost centers. In most cases, the hospice's apportionment was based on the cost center's direct costs. For the remaining hospices (he could not recall how many), he apportioned overhead costs based on the ratio of a cost center's direct costs to total hospice costs.

An additional 17 hospice cost reports assigned all square footage to one direct patient cost center, even though costs were reported in multiple cost centers. Thus, as all overhead costs were assigned to one type of service, the costs of that service were overstated and the costs of the other three types of service understated.

Conclusions

HCFA's unit cost estimates are computed with a formula using cost data—supplied by hospices—that our review shows are incomplete, inconsistent, and inaccurate. Thus, we could not determine if Medicare hospice payment rates are reasonable.

Recommendations to the Secretary of HHS

We recommend that the Secretary of HHS direct the Administrator of HCFA to take steps to improve the quality of cost data received from hospices. Based on our review of cost data, the Administrator should modify the cost-reporting form and instructions to assure reporting of

- all appropriate labor hours used to provide services at patients' homes,
- parent agency or hospital administration and general overhead costs attributable to the hospice,
- hospital ancillary service costs for hospice patients, and
- all inpatient service costs during the cost-reporting time period in which they were incurred.

We also recommend that the Secretary direct the Administrator to

- use factors other than square footage (such as the share of direct cost attributed to a cost center) to apportion overhead costs to cost centers, and
- conduct thorough audits of a representative sample of cost reports to assure complete and accurate data for calculating unit costs and ultimately setting prospective payment rates.

Agency Comments and Our Evaluation

In commenting on a draft of this report, HHS stated that it agreed that there were many problems with hospice cost data and that they were inaccurate and incomplete. It stated that while GAO seems to be blaming HCFA's cost report format and instructions, changing the form will not alleviate the data inaccuracies. HHS stated that hospices say the data is inaccurate because they lack resources to prepare accurate cost reports.

We believe that the inadequacies in the cost data have various causes, including the hospices' generation of the data and the cost report form. Neither is entirely at fault, but both appear to be contributing factors. Improvements in the cost report and the instructions for completing it should help improve data quality because, as discussed in this chapter, at least some hospices misinterpreted or did not understand requirements.

HHS agreed that the formula used by HCFA to compute unit costs for services could result in misallocation of overhead costs, but also stated that GAO's suggested use of accumulated direct costs would not be an improvement. Our recommendation is that HCFA should use a factor other than square footage to allocate overhead costs to cost centers. Use of the share of direct costs attributed to a cost center was included in the report as an example of a method. As discussed in this chapter, using square footage does not yield adequate cost allocations to the various types of service and a new allocation basis is needed.

HHS also agreed that audits of hospice cost reports would help provide more complete and accurate data, but noted that the cost-to-savings ratio is minimal and that only a limited sample of hospice reports would be audited in fiscal year 1990.

We did not recommend auditing a sample of hospice cost reports for the purpose of identifying payments that could be recouped or because we believe hospice rates are overstated and would be reduced by basing them on audited data. Rather, we believe that the problems we found with hospice cost data show that there is no assurance that hospice

rates based on that data are reasonable as envisioned by the law and regulations. One way to improve the assurance that rates are reasonable is by using adequately audited cost data to set them. Because adequacy of rates appears to be a major impediment to hospice participation in Medicare, improving assurance of reasonable rates should help improve participation.

Hospice Quality Requirements Can Be Enhanced

State officials responsible for inspecting and certifying hospices generally believe that the Medicare self-assessment[1] requirement is sufficient to ensure that hospices are capable of providing high quality care. When we compared Medicare certification requirements with standards developed by states for licensing hospices and by JCAHO for accrediting hospices, we found no requirements or standards that could be added to the Medicare certification requirement that would enhance the quality of hospice care.

HCFA requires state certification surveyors to perform home visits to hospice patients. State surveyors believe home visits, if effectively performed, can enhance the quality assurance process. But as HCFA does not require the states to report that home visits were made or the results of the visits, it cannot effectively monitor implementation of the home visit requirement.

The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) (P.L. 100-203) contained certain home health aide training and patients' rights provisions. These were designed to improve quality of care in home health agencies and hospices affiliated with home health agencies—but did not apply to hospices that are not so affiliated. Extending the provisions to other hospices could help assure quality of care at all hospices.

Medicare Requirements Sufficient to Ensure Quality Hospice Care

In discussions with state survey and certification officials, we identified five existing Medicare requirements that, in combination, provide reasonable assurance that hospices are capable of providing quality care. Currently, hospices must

- have an ongoing quality assurance program, referred to as self-assessment, that monitors care, identifies and resolves problems, and suggests ways to improve patient care. An active quality review program helps emphasize to staff the importance of quality of care by showing the hospice's commitment to quality.
- use an interdisciplinary group composed of a physician, registered nurse, social worker, and counselor to develop, and periodically review and update a plan of care for each patient and to supervise its implementation. Using a team approach helps assure that all of a patient's needs, both physical and mental, are considered and addressed.

[1]Hospices are required to implement and report on activities and mechanisms for self-monitoring quality of care. These activities and mechanisms must identify and resolve quality of care problems and make suggestions for improving quality of care.

- furnish services in accordance with the plan of care, which should include an assessment of patient needs, the services necessary to meet those needs, and the frequency at which the services are needed. Such a comprehensive plan provides care givers a sound basis for furnishing the services necessary to quality care.
- have a governing body responsible for setting policy and assuring that quality care is provided. This requirement establishes another oversight function with an emphasis on quality.
- directly provide nursing care, medical social services, physician services, and patient and family counseling. Having hospice employees provide these care services helps assure that the hospice maintains direct control of patient care.

While we did not attempt to validate these requirements, 47 of the 52 state survey and certification officials we contacted said that they can ensure the capability of certified hospices to provide quality patient care. Four others indicated their states have no certified hospices,[2] and the one remaining official preferred not to offer comments. Further, 71 percent of the state officials cited HCFA's requirement for home visits as an enhancement to the quality assurance process.

When HCFA compared Medicare hospice requirements with JCAHO standards (developed in 1984 for accrediting hospices), it found the two substantially similar and identified no additional standards to augment quality assurance.

Home Visits Can Help Ensure Quality Hospice Patient Care

As an additional means of assuring the quality of hospice services, HCFA requires that state surveys include visits to hospice patients' homes. HCFA discussed the merits of home visits in the preamble to the final hospice regulations (which were published in December 1989). Because hospices provide the bulk of patient services in the home, it said, the palliative care services provided under the hospice benefit are materially different in many ways from other Medicare services . HCFA further stated that hospice surveys were insufficient to evaluate program compliance fully and to assure quality patient care.

[2]Four states—Alaska, Maine, New Hampshire, and Utah—had no certified hospices as of July 31, 1988.

HCFA established home visit requirements to augment the survey and certification and claims review processes. In an appendix to the operating manual for state surveyors, HCFA required that the surveyors conduct home visits to verify hospice compliance with the conditions of participation and as a quality assurance check. The claims review manual also was amended to call for hospice fiscal intermediaries to conduct home visits to augment the claims review process and ascertain if patients and family members are satisfied with the care provided.

At least three home visits by state surveyors for each hospice are required annually. Beneficiaries to be visited are selected from those that require four or more types of service, require two or more subcontracted services, make frequent hospice contacts, have filed a complaint, or have been at home under hospice care for at least 2 months. If no beneficiaries meet the criteria, random selection is used. At the time we made our contacts, 41 of the 52 state survey officials said they were making home visits. Of the remainder, seven states—Florida, Hawaii, Kansas, Montana, Ohio, South Carolina, and West Virginia—were not making home visits and four states had no certified hospices. The reasons given (when known) by state officials for not making home visits included the following:

- Development of state hospice licensing standards was delaying implementation of home visits.
- The program includes only newly certified hospices with too few beneficiaries to make a meaningful patient selection.
- Home visits are unnecessary.

During a home visit, state surveyors gain insights about the quality of hospice care by observing the services being delivered, according to 37 of the officials in states making home visits. Surveyors verify that the patient's plan of care is being followed and observe delivery of care in the home. They also interview patients and family members to obtain their opinions about the care provided by hospice personnel. The results of home visits are considered in determining whether a hospice becomes or remains Medicare-certified.

To verify that state certification teams are conducting home visits, we visited nine states—California, Colorado, Florida, Georgia, Maryland, New Jersey, Pennsylvania, Virginia, and Texas—which were responsible for certifying 41 percent of participating hospices. All nine used home visits to determine whether hospices adhere to the patients' plan of care and as a quality assurance check.

Home visits are an effective way to move the certification process beyond assessing hospice capabilities to observing the actual care provided, state surveyors in three states told us. The surveyors said that they attend hospice interdisciplinary group meetings and observe the process used to develop, review, and update plans of care. They also reviewed the clinical records of the patients to be visited. In these ways, they were prepared to verify through the home visit whether patients' needs were being met.

However, HCFA is not ensuring that the full benefits of the home visits are realized. The reporting forms surveyors fill out and submit to HCFA do not call for, or even provide space to insert, the results of the visits. In fact, the forms do not even ask if home visits were made. Thus, HCFA cannot determine from the survey reports it receives whether states are complying with the home visit requirement or whether problems with quality are being found. We believe such information would be useful to HCFA in meeting its responsibilities for establishing and monitoring quality of care requirements for hospices. If a problem or problems arise, HCFA could act to modify requirements to address the situation. Alternately, if the home visits show no problems, HCFA could be more confident that quality care is being furnished.

Home Visits by Fiscal Intermediaries Probably Ineffective for Quality Assurance

During the 2-year period spanning fiscal years 1986 and 1987, only 12 of the 60 intermediaries required to perform home visits actually made them. Intermediary officials cited several reasons that home visits were not made. Before a visit is scheduled, claims reviewers must wait until claims are approved, which can be several months after services are delivered to the patient. Services that prompt a home visit under HCFA guidelines—continuous home and acute inpatient care—often indicate the patient is near death. If home visits are conducted after the patient is deceased, it is difficult to review past services for appropriateness and quality of care. Also, home visits after a patient's death can be awkward, because the family is still in mourning.

On October 7, 1987, HCFA instructed its regional offices to consider alternatives to the requirement for home visits by intermediaries to ensure quality of care. It advised that home visits could be conducted on an as-needed basis. According to a HCFA official, this was done after a review of intermediary home visit reports determined that the visits were not effective because no quality assurance problems were being identified.

Home Health Aide Training and Patients' Rights: Possible Enhancements to Hospice Quality Assurance

OBRA-87 expanded the requirements for home health agencies and hospices affiliated with home health agencies to include a training and competency evaluation program and patient rights provisions. Home health aides now must complete a training program and demonstrate continuous competency in providing certain health care services.

The OBRA-87 provisions guaranteed patients the right to

- be fully informed in advance of and participate in planning the care and treatment to be provided and changes to the plan,
- voice grievances about the care that is provided (or not provided) without fear of discrimination or reprisal,
- have confidentiality of clinical records,
- have property treated with respect,
- be fully informed in advance, orally and in writing, about entitlement to coverage under Medicare, charges not covered, and changes in covered and not covered charges,
- be fully informed in advance, in writing, about rights and obligations,
- be informed of the availability of the state home health agency hot-line.

These provisions do not apply to hospices not affiliated with home health agencies.

Officials from JCAHO and hospice associations have expressed positive opinions concerning the OBRA-87 training, competency, and patient rights provisions. They believe the provisions should be extended to all Medicare hospices, not just those affiliated with home health agencies. But these officials felt Medicare's home health agency requirements for training and competency evaluation might have to be modified somewhat to allow for the particular palliative care needs of hospice patients.

Conclusions

The Medicare requirement for hospices to conduct self-evaluations of their quality assurance systems coupled with other Medicare standards provide reasonable assurance that Medicare-certified hospices are capable of providing quality patient care. We could identify no additional hospice standards—state or private—that would provide additional assurances.

HCFA has implemented an administrative directive requiring states to conduct visits to patients' homes. States are required to go beyond just determining whether a hospice is capable of providing quality care by

directly observing patient care in the home and determining whether quality patient care actually is being provided.

OBRA-87 provisions dealing with privacy and dignity of patients can enhance quality assurance in the hospice program. However, these provisions apply only to home health agency-affiliated hospices. The provisions are just as appropriate for hospices not affiliated with home health agencies.

Recommendation for the Congress

We recommend that the Congress adopt, for all hospices, training and patients' rights provisions similar to those that OBRA-87 specified for home health agencies. If the Congress adopts these provisions, the Secretary may need to modify the regulations implementing the training and competency requirements for home health agencies to reflect any special circumstances faced by hospices.

Recommendation to the Secretary of HHS

We recommend that the Secretary of HHS direct the Administrator of HCFA to require that state surveyors report all home visits made and their results.

Agency Comments and Our Evaluation

In commenting on a draft of this report, HHS said that it agrees that state surveyors should report the results of all home visits and that HCFA's state operations manual requires the results of home visits to be recorded on the survey report.

Our concern with reporting for home visits involved not the requirements, but HCFA's survey report form. Because the form did not provide for reporting home visits, HCFA cannot be sure it has complete data on all home visits and their results.

Hospice Database Synthesis and Sample Selection Methodology

Database Synthesis

Our goal was to develop a complete list of hospices that were not Medicare-certified. To do this, we requested (1) membership lists from the National Hospice Organization and the Hospice Association of America and (2) a hospice listing used by the Joint Commission on Accreditation of Health Care Organizations in a hospice study done for the Health Care Financing Administration. The combined lists provided us with a starting database of 4,596 hospice names. Generally, data in each hospice record included hospice name, address, telephone number, hospice type (hospital-based, home health agency-based, nursing home-based, freestanding, or coalition type), and a contact person. However, a significant number of the records did not include hospice type.

To refine the database, we used a computerized cross-matching technique. We matched the files on various identifiers such as hospice name, address, and telephone number to identify duplicates within and among the three files.

The process we used to develop and refine the data base was as follows:

1. Each file was internally matched to eliminate duplicate records within the files. This enabled us to eliminate 10 records from the NHO file, 32 from the HAA file, and 54 from the JCAHO file.

2. Next, each file was matched against the NHO file, which served as the master file. We matched the HAA file against the NHO file, the JCAHO file against the NHO file, and finally, the HAA file against the JCAHO file. This process resulted in the elimination of 1,540 duplicate records.

3. We reviewed the matched listings and performed a number of data refinement steps, including deleting cancer treatment centers, visually reviewing the lists for duplicates, and contacting some hospices to verify address information. This resulted in eliminating 490 additional records determined to be either duplicates or records that were not actually hospices.

4. The three files then were combined to form a validated database without duplicates and containing—to the extent we could determine—only active hospice care providers. Also, by manually matching the combined file against a file of certified hospices (provided by HCFA) we were able to assure that the file contained only noncertified hospices. This process eliminated 524 more records from the database.

5. The combined database consisted of 1,946 noncertified hospices that served as our master list of hospice care providers and the universe from which we selected our random sample to survey.

Sample Selection Methodology

From the synthesized hospice database of 1,946, we randomly sampled 710 hospice records. The sample was stratified by hospice type, as shown in table I.1.

Table I.1: Type and Number of Hospices Included in Sample

Hospice type	No. in universe	No. sampled
Home health agencies	412	150
Freestanding	452	150
Nursing homes	13	13
Hospitals	361	150
Other (1)[a]	97	97
Other (2)[b]	611	150
Totals	**1,946**	**710**

[a]Coalition models

[b]Hospice type not indicated on original file

Because of the large number of hospice records with missing type indicators, we decided to use hospice-provided information from returned questionnaires to further classify these hospices. From the responses received and exhaustive follow-up with nonrespondents, we were able to account for a substantial number of missing hospice types and also remove identified nonhospices from the sample. The results of this process and the restructured sample are shown in table I.2.

Table I. 2: Restructured Hospice Sample

Hospice type	Original sample	Removed	Restructured sample
Home health agencies	150	53	97
Freestanding	150	13	137
Nursing homes	13	3	10
Hospitals	150	35	115
Other (1)	97	13	84
Other (2)	150	91	59
Totals	**710**	**208**	**502**

Questionnaire responses totaled 308 or 61 percent of the restructured sample. Projections to the universe, based on the 502 hospices in the restructured sample, are shown in table I.3.

Table I. 3: Projected Universe of Noncertified Hospices

Hospice category	Restructured sample	Projected universe
Hospices that completed questionnaires	308	786
Hospices that indicated they were already certified (instructed not to complete questionnaire)	551	48
Hospices that indicated they had already applied for certification (instructed not to complete questionnaire)	34	87
Hospices that did not respond	105	269
Estimated universe of noncertified hospices	502	1290

Methodology Used to Separate Relatively Qualified Hospices From Noncertified Hospice Sample

A major objective of our survey questionnaire was to identify the hospice benefit program factors that influence qualified noncertified hospices not to pursue Medicare certification. To do this, we had to determine from the survey responses which of the hospices were in a better relative position to meet Medicare certification standards and thus be considered qualified. We included in the survey a series of questions on hospice patient care designed to be used as a hospice self-assessment of capability to meet certain Medicare standards. Of course, the actual ability of the hospices to meet these standards could be determined only by a certification survey. Using the resulting responses, we ranked the hospices (the highest rank being most qualified relative to the others and the lowest rank the least qualified compared with the others).

To rank the hospices, we assigned scores to the selected patient care questions. This allowed hospices to accumulate points to the extent that their responses indicated compliance with Medicare standards.

We separated the patient care questions into five categories with maximum scores totalling 195. JCAHO accreditation was counted and given a nominal score of 5 for three reasons:

1. By providing a score, it facilitated tracking the JCAHO-accredited hospices.

2. JCAHO accreditation standards are similar to those of Medicare, so we felt high scores by accredited hospices could provide a degree of validity to our scoring system.

3. The accredited hospices with the lowest scores might give us a benchmark score to separate the hospices into two groups: relatively qualified to meet certification standards and insufficiently developed to meet Medicare standards.

The scoring categories and maximum point scores for each category were

- JCAHO accreditation, 5;
- Assumption of financial responsibility, 20;
- Patient care functions, 65;
- Quality assurance systems, 18;
- Patient care services, 87; and
- Use of volunteers, 5.

Final point scores ranged from 192 (of 200 possible) on the high end to 12 on the low end. After a review of the rankings, we subjectively chose 112 as a cut-off score because 59 of the 61 JCAHO accredited hospices fell above this score. Hospices with scores of 112 and above totaled 231, while 77 scored less than 112. On inspection, we determined that one of the two JCAHO hospices that fell below 112 (total score 98) did not complete the patient care services question, thereby scoring zero for that category. The other hospice (total score 105) indicated that it provided a large percentage of services on a contract basis, thus scoring very low on patient care services (the most heavily weighted category). The 59 JCAHO-accredited hospice scores ranged from 192 to 113 (just above our cut-off score), with 48 included in the top 100 ranked hospices.

To test what effect, if any, moving the cut-off score would have on the number of qualified hospices, we analyzed the scores 10 percent above and below the cut-off score. At the 123 level (10 percent above), the qualified hospice count would be 211, and at the 101 level (10 percent below) it would be 251. This range did not contain a disproportionate number of hospices with one particular score, therefore, we maintained the original cut-off. From this test and our other scoring rationale, we concluded that the cut-off score of 112 and the overall methodology used to identify relatively qualified hospices are reasonable.

Our analysis of questionnaire data relating to the factors that influence noncertified hospices not to pursue certification is focused exclusively on the group of hospices we isolated as relatively qualified. Qualified hospices not included in the analysis are hospices that indicated they plan to apply for Medicare certification within 1 year or are opposed to accepting government funding. All analytical results shown in this report used weighted data projected from the sample.

Program Concerns That Influenced or Affected GAO-Surveyed Hospices

Medicare provision	Qualified noncertified hospices			Certified hospices			Unqualified noncertified hospices		
	No.	%	Rank	No.	%	Rank	No.	%	Rank
General inpatient care base rate	268	66	1	259	83	1	53	40	12
Routine home care base rate	251	62	2	252	81	2	59	43	9
Inpatient respite care base rate	231	58	3	221	70	7	67	49	3
$9,010 annual cap	235	57	4	101	33	14	45	33	16
210-day lifetime benefit limit	233	57	5	250	80	3	67	49	2
Physician certification of terminal illness	222	54	6	226	72	5	66	47	4
Continuous home care base rate	220	55	7	226	72	6	58	43	10
20-percent limitation on inpatient care days	199	49	8	84	27	19	57	43	8
Continuing professional case management/inpatient services contract	198	49	9	158	62	9	54	39	13
Homemaker services	170	42	10	87	28	17	42	30	19
Physician on interdisciplinary team (IDT)	158	39	11	97	31	16	62	44	5
Speech-language pathology services	154	38	12	97	31	15	57	41	11
Patient's informed consent	153	38	13	107	34	12	27	21	27
2-day limit to obtain physician certification	147	36	14	245	78	4	37	27	23
Occupational therapy services	145	36	15	109	35	11	59	43	7
Core services—physician	144	36	16	55	18	22	52	38	14
Core services—bereavement counseling	137	33	17	210	67	8	41	31	17
5-day limit on inpatient respite care	136	33	18	116	37	10	36	26	24
Physical therapy services	132	33	19	104	33	13	59	43	6
Dietary/nutritional counseling services	125	31	20	82	26	20	42	30	20
Home health aide services	120	30	21	69	22	21	33	24	26
Core services—medical social services	113	28	22	84	27	18	52	37	15
Core services—nursing	113	28	23	49	16	23	39	28	21
Core services—spiritual counseling	91	22	24	47	15	26	34	24	25
Medical social worker on IDT	80	20	25	49	16	24	42	30	18
Pastor on IDT	73	18	26	48	15	25	39	28	22
Registered nurse on IDT	53	13	27	20	6	27	130	94	1

Note: Responses shown are projections from hospice sample data.

Comments From the Department of Health and Human Services

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

AUG 22 1989

Mr. Lawrence H. Thompson
Assistant Comptroller General
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

Enclosed are the Department's comments on your draft report, "Medicare: Program Provisions and Payments Discourage Hospice Participation." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report, "Program
Provisions and Payments Discourage Hospice Participation"

Overview

According to GAO, nonparticipating hospices sampled during its national survey indicated that they chose not to participate in Medicare because of: (1) language required in hospices' certification of terminal illness related to the certainty of the physician's prognosis of death; (2) the requirement that hospices obtain contracts with hospitals for inpatient services; (3) limits placed on aggregate payment amounts and inpatient days; and (4) payment rates.

GAO reports that participating hospices agreed that the certification language is a problem. However, hospices did not have similar concerns about the provisions related to hospital contracts and payment limits. This leads GAO to conclude that the problems participating hospices have with these provisions may be more perceived than real.

GAO reports also that participating hospices agreed that the payment rates are a major factor adversely affecting their operations. GAO could not determine the reasonableness of the payment rates because cost data reported by hospices (used in the rate calculation) were inaccurate, inconsistent, and incomplete. A contributing factor to the problems with the cost data was inadequacies with the Health Care Financing Administration's (HCFA's) cost report form and the related instructions. In addition, GAO believes the formula used by Medicare to compute unit costs for services—which are the basis for the hospice payment rates—could result in misallocation of overhead costs among the care levels. GAO believes that the reasonableness of hospice payment rates cannot be determined until improvements are made in the accuracy and completeness of cost data provided by the hospices and in the formula HCFA uses to calculate unit costs.

See GAO response 1.

We note and agree that there are many problems with the cost data. However, hospice cost analysis conclusions reached in this GAO report are based on preliminary data obtained from HCFA. Although HCFA offered to make the finalized data base available to GAO on several occasions, GAO has not yet obtained these data from HCFA.

A significant number of changes were made to the preliminary hospice data, including the use by HCFA of the direct-cost overhead allocation basis suggested by GAO for a small number of hospice providers failing to report square footage figures. Should GAO wish to utilize the finalized hospice data used by HCFA in the final report, HCFA will make these data available.

Page 2

GAO Recommendation

That the Secretary of HHS direct the Administrator of HCFA to change the wording in the Medicare regulations regarding the physician's certification of the illness to include the clarifying statement that the individual's medical prognosis is that his or her life expectancy is six months or less "if the terminal illness runs its normal course."

Department Comment

The current regulation reflects the statutory definition of the term "terminally ill." Section 1861(dd) specifies that "An individual is considered to be "terminally ill" if the individual has a medical prognosis that the individual's life expectancy is 6 months or less." We believe that any prognosis would be based on the expectation that an illness would run its normal course. It is understood that physicians cannot foresee unexpected circumstances. For this reason, we do not believe it is necessary to recommend that Congress expand its definition of "terminally ill" or to make a regulatory change to this effort.

GAO Recommendation

That the Secretary of HHS direct the Administrator of HCFA to take steps to improve the quality of cost data received from hospices. Based on our review of cost data, the Administrator should modify the cost reporting form and instructions to assure reporting of:

-- all appropriate labor hours used to provide services at patients' homes;

-- parent agency or hospital administration and general overhead costs attributable to the hospice;

-- hospital ancillary service costs for hospice patients; and

-- all inpatient service costs during the cost reporting time period in which they were incurred.

Department Comment

See GAO response 2.

GAO's recommendations are based on the fact that the cost data submitted by the provider (via the hospice cost report) were inaccurate or incomplete. GAO appears to be placing the blame for this problem on the cost report and believes that its recommendation

will alleviate this problem. We believe that the instructions adequately identify the data to be submitted to the fiscal intermediary for review prior to submission to HCFA. Where insufficient or inaccurate data is submitted to HCFA (by way of the fiscal intermediary) the fiscal intermediary has the responsibility of checking and correcting the information submitted. If this procedure is not followed, the data being given to HCFA can only be presumed to be correct until otherwise proven wrong. This is not th fault of the forms and changing cost report instructions will not alleviate the inaccurate information submitted.

In many instances, provider-based hospices have failed to submit hourly statistics to support costs reported and vice versa. HCFA instructions state that costs and hours must be shown for each discipline under "Visiting Services." Provider-based hospices complain that they do not have the personnel and funds to maintain the requested records for cost reporting purposes. It is noted that fiscal intermediaries submit to HCFA desk reviewed provider-based hospice schedules that do not tie-in with the data shown on the hospital's or home health agency's line items for the hospice cost center. However, as previously discussed, it is difficult to verify through desk review, costs and statistics which are not properly reported. We will perform a limited number of indepth audits of hospital based hospices in FY 90 in order to determine the availability (and extent) of cost/statistical data.

Every time HCFA initiates a new cost report form, and every time HCF revises a cost report form, that form and its instructions are first issued to other components of the Government (e.g., General Accounting Office and Office of Inspector General), to all of our fiscal intermediaries, to user representative groups (e.g., National Hospice Organization), and to a sampling of the users (e.g., free standing hospices as well as provider-based hospices) for review and to solicit comments. Corrections, clarifications, and meaningful alternatives derived from these comments are incorporated into the forms and instructions before a final version is published.

In addition, HCFA has participated in communications with the user representative groups for the purpose of educating the user. HCFA also considers comments from these groups and the providers in order to improve the forms and instructions where appropriate.

Page 4

GAO Recommendation

Also, that the Secretary direct the Administrator to:

-- use factors other than square footage (such as the share of direct cost attributed to a cost center) to apportion overhead costs to cost centers; and

Department Comment

See GAO response 3.

While we agree in part with GAO's assertion that the analysis formula used by HCFA to compute unit costs for services could result in some misallocation of overhead costs among the care levels, GAO's recommended alternative will not, in our opinion, result in improved accuracy. GAO suggests the use of accumulated direct costs to allocate overhead costs, which tends to skew the allocation of overhead costs toward high cost inpatient care categories. Where hospices merely contract for inpatient care (rather than providing it directly), this allocation methodology is particularly inaccurate in that large amounts of overhead costs would be assigned to inpatient areas in disproportion to hospice overhead resources expended on inpatient care contract negotiation and oversight. Although HCFA used this direct cost alternative in cases where hospices were unable to provide square footage figures, we continue to believe that accurate square footage data will result in the most simple and equitable allocation of overhead costs to the various care categories.

The apportionment of overhead costs (for example, Administrative & General and other Parent or shared costs, and Contracted costs) is computed using Generally Accepted Accounting Principles and time established methods used by the Medicare program for reimbursement in other provider settings. "Square Feet" as a basis for stepping down costs is used in every other cost report in Medicare.

GAO's suggested alternative factor of "direct cost attributable to a cost center" is not a new basis of allocation and is in fact used to apportion certain costs which cannot be identified by any other tangible means. However, any method of reporting must be consistent and applied uniformly to all providers. Since most providers do not find fault with the use of "Square Feet" as a basis where it is applied, and it does provide HCFA with the data needed when it is properly applied, the fault is not in the method or the form, but rather in the misuse of that method.

Page 5

GAO Recommendation

-- conduct thorough audits of a representative sample of cost reports to assure complete and accurate data for calculating unit costs and ultimately setting prospective payment rates.

Department Comment

See GAO response 2.

We agree that there are problems with the hospice cost data, and that audits would help provide more complete and accurate data. But, hospice audits are a low priority because the cost to savings ratio from such audits is minimal compared to the cost to savings ratio from hospital (PPS) audits. Therefore, in order to maximize the effective use of our audit funding, we plan to do detailed field audits in FY 90 on a limited sample of hospice reports.

GAO Recommendation

That the Secretary of HHS direct the Administrator of HCFA to require that State surveyors report all home visits made and their results.

Department Comment

We agree and in fact, HCFA's State Operations Manual provides instructions for State agency surveyors in Appendix B concerning Interpretive Guidelines for surveying hospices. Part II of Appendix B covers Hospice Home Visit Procedures and specifically states, "The results of such visits must be recorded on the Survey Report."

Other Matters

1. HCFA's Office of Research and Demonstrations (ORD) can provide a copy of a major cost study of nonparticipating hospices that was conducted as part of the evaluation of the hospice benefit but was not referenced in the draft GAO report. Copies of the report by Jack Martin & Company, certified pubic accountants, have been given previously to GAO staff in Woodlawn; but it appears that the regional GAO staff may not have received a copy. We recommend that GAO review the detailed cost analyses contained in the report prior to finalization of its report.

   See GAO response 4.

   The results of the Jack Martin & Company survey of reasons for nonparticipation in the Medicare hospice program are similar to those identified in the GAO survey. The Martin study found that the majority of the hospices in the study "were indeed within the

Page 6

limits of the Medicare Hospice Benefit's per patient costs and use of inpatient care." The study report notes that "[t]here is a clear need for administrators to gain greater awareness of their hospices' financial structures to enable them to properly consider Medicare certification."

2. ORD can also provide a copy of the cost analysis chapter of the Abt Associates, Inc., draft final report to the Medicare Hospice Benefit Program Evaluation. Abt Associates also analyzed the Jack Martin & Company noncertified hospice cost data and report in table 2.11 that about 80 percent of the noncertified community home health agency sponsored and independent "freestanding" hospices would have operated with a profit under the national average Medicare hospice payment rates. As with the certified hospice cost report findings, Jack Martin & Company found that noncertified hospital-based hospices are more expensive, but that about 65 percent of them would have operated at a profit under the FY 85 and 86 hospice payment rates.

   This does not dismiss the valid criticisms by GAO about the generally poor quality of the submitted certified hospice cost reports and the subsequent difficulties in obtaining intermediary auditing support to correct the problems. However, it does support the analyses of the usable certified hospice cost reports that were conducted by both HCFA and by Abt Associates.

Technical Comment

In the text of the draft GAO report there appears to be a typographical error on page 27: 25 percent of the estimated number of hospices as compared with a reported 35 percent in the Executive Summary on page 2. The 35 percent is the correct number (609/1700 = 35.8 percent). The methods used by GAO and reported in the draft appear reasonable and quite thorough, with the exception of the above-mentioned omission of the results of the independent CPA-collected cost data from the representative sample of noncertified hospices.

See GAO response 5.

GAO Response to HHS Comments

1. The Department of Health and Human Services noted that we had used preliminary cost data obtained from the Health Care Financing Administration for some of the analyses in this report and that finalized data had become available and had been offered to us. We did not redo our analyses when the finalized data became available because the finalized data still would not have provided us with a measure of the reasonableness of the hospice payment rates. As stated in HHS's comments, "there are still many problems with the cost data," and items in the data, such as apportionment of overhead costs to cost centers, still had to be estimated by HCFA. While the data may have been finalized, we did not believe the quality of the data had improved.

2. HHS agrees that the hospice cost data is inaccurate and incomplete, but says the blame should not be placed on HCFA's hospice cost report. Chapter 3 of this report does not place the blame for inaccurate and incomplete data solely on the hospice cost report. We cite several contributing factors, including inaccurate data provided by the hospices, incomplete data provided by the hospices, and inadequacies of the hospice cost report. These factors, in total, result in cost data that is inadequate for determining the reasonableness of the hospice payment rates. Our recommendation in chapter 3 for thorough audits of a sample of cost reports further demonstrates our belief that the cost data problem is at least partially due to inaccurate and incomplete data provided by the hospices. Audits are needed to ensure that hospices provide complete and accurate data so that HCFA can establish a meaningful database to use in calculating hospice payment rates.

3. HHS agrees that the unit cost calculation formula could result in misallocation of overhead costs, but disagrees that the use of accumulated direct costs would result in an improvement. The reference to direct costs in our recommendation was mentioned as an example of an alternative to using square footage to apportion overhead costs to cost centers. Other methods could be used to apportion overhead costs. Direct costs was mentioned primarily because it is a method that has been used by HCFA when square footage data was not available. In any event, the small physical facilities used by many hospices make the use of square footage highly questionable as an accurate method of apportioning overhead.

4. HHS offered us copies of two hospice studies that contain information on reasons why hospices are not participating in Medicare and cost data. We had copies of both the Jack Martin and Company study and the Abt Associates, Inc., draft final report. The studies were completed during

our review, and we analyzed them to determine if they affected the results of our work. As HHS noted, these studies do not dismiss our findings concerning the quality of cost data or the need for audit support.

5. HHS pointed out a typographical error in our estimate of the percentage of hospices that currently participate in Medicare. In the Executive Summary, we cited 35 percent of hospices as participating in Medicare, while in chapter 2 we used a figure of 25 percent. We revised chapter 2 to show that 35 percent of hospices currently participate in Medicare.

Comments From the Hospice Association of America

Joan P. Lowell
Chairman

August 7, 1989

Mr. Lawrence H. Thompson
Assistent Comptroller General
Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

On behalf of the Hospice Association of America (HAA), which represents over 1200 hospices from across the country, I would like to thank you for the opportunity to comment on the GAO draft report, "Medicare: Program Provisions and Payments Discourage Hospice Participation."

HAA commends GAO for its comprehensive and thoughtful review of the Medicare hospice benefit. We agree with the major points made on the problem areas in the utilization of the benefit.

However, we think it is important to comment on the lack of Medicare certified hospices in rural areas of the country and resulting dearth of services for Medicare patients in those areas. Our country is now suffering a shortage of registered nurses which is likely to intensify in the future. Many of our members believe the conditions of participation for Medicare certification should be amended to permit contracting for nursing services. A patient could then benefit from continuity of care by allowing the same home care nurse (also trained in hospice care) to provide care when the patient moves to the hospice program. Eliminating the need for a totally separate nursing staff could encourage more home care providers to acquire hospice certification and thus make hospice care more readily available.

We agree with the following recommendations:

Physician certification

1. The draft report recommends that the language in the physician's certification of terminal illness should include the clarifying clause "if the terminal illness runs its normal course". We concur with this recommendation. We would like to further recommend that HCFA follow the same certification practice, afforded all other Medicare providers, of allowing hospices to begin service to the patient with a doctor's verbal order within 48 hours, followed by a written certification within 8 days.

Section 1814(a)(7) of the Social Security Act states that ". . . (a physician) certify, not later than two days after hospice care is initiated, that the individual is terminally ill. . . ." HCFA has chosen to require that the certification be written and signed within that two day period. Hospices, especially those who do not have in-patient facilities (the vast majority), find the

519 C Street, N.E. • Stanton Park • Washington, D.C. 20002 • (202) 547-5263

two-day signature requirement overly burdensome and we do not believe that it serves a useful purpose.

Hospice cost reports

2. The draft report recommends that HHS improve the accuracy and completeness of the cost data reported by hospices and HCFA's unit cost calculations in order to set accurate reimbursement rates for Medicare hospice providers. It also notes that no hospice has ever reached the yearly payment cap. We believe that one reason for this is that although the cap has been increased to reflect inflation, the daily reimbursement rates have remained the same since 1986.

Hospices need an immediate increase in the daily reimbursement rates, as well as provision for outlier costs, to reflect the impact of inflation and the development of new high-technology palliative treatments. When the payment rates were developed, they were specifically designed to relate to care for terminally ill cancer patients. Currently, hospices are being asked to expand their services to non-cancer patients whose costs of treatment are much higher, such as patients with terminal heart disease and chronic obstructive pulmonary disease. However, they are being asked to do this at the reimbursement rate set in 1986 for less costly care.

Due to current lack of adequate cost data, there would necessarily be a long time lag before HCFA could update the reimbursement rates. We are advocating that Congressional action be taken this year to increase hospice daily reimbursement rates. The Committee on Ways and Means has included in its package an inflationary rate increase for hospices which we heartily endorse. We would greatly appreciate your support for this action.

Quality care requirements and patient rights

3. HAA agrees with the report's finding that current Medicare standards provide assurance that hospices are providing quality patient care. We further agree with the recommendation that patients' rights provisions should be developed for hospices.

Hospices care for thousands of terminally ill Americans and their families every year and yet represented only .001 percent of 1988 Medicare expenditures. Our members are not asking that they be relieved of their own fundraising responsibilities and their reliance on volunteers and community involvement. However, adequate reimbursement by Medicare is crucial to enable hospices to provide their patients with the most effective and highest quality care possible.

Again, HAA would like to thank GAO for focussing on the major problems involved in the Medicare hospice benefit and hope the recommendations will be adopted. We would be happy to provide whatever assistance you might require.

Sincerely,

Joan P. Lowell
Chairman

Major Contributors to This Report

Human Resources Division, Washington D.C.	Michael Zimmerman, Director, (202) 275-6195 Thomas G. Dowdal, Assistant Director Kenneth E. Lightner, Jr., Assignment Manager
Philadelphia Regional Office	Janet K. Barbee, Regional Assignment Manager David B. Pasquarello, Evaluator-in-Charge
Atlanta Regional Office	Don K. Riffe, Regional Assignment Manager Clarence L. Tull, Site Senior
San Francisco Regional Office	Thomas P. Monahan, Regional Assignment Manager Harry Medina, Site Senior