

GAO

Report to the Committee on Finance, U.S. Senate, and the Committee on Ways and Means, House of Representatives

October 2004

MEDICARE HOSPICE CARE

Modifications to Payment Methodology May Be Warranted





Highlights of [GAO-05-42](#), a report to the Committee on Finance, U.S. Senate, and the Committee on Ways and Means, House of Representatives

Why GAO Did This Study

The Medicare hospice benefit provides care to patients with a terminal illness. For each patient, hospices are paid a per diem rate corresponding to one of four payment categories, which are based on service intensity and location of care. Since implementation in 1983, the payment methodology and rates have not been evaluated. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 directed GAO to study the feasibility and advisability of updating Medicare's payment rates for hospice care. In this report, GAO (1) compares freestanding hospices' costs to Medicare payment rates and (2) evaluates the appropriateness of the per diem payment methodology. Because of Medicare data limitations, it was not possible to compare actual payments to costs or examine the services provided to each patient.

What GAO Recommends

GAO recommends that the Administrator of the Centers for Medicare & Medicaid Services (CMS) collect comprehensive, patient-specific utilization and cost data on hospice visits and services, and using these data, determine whether modifications to the payment methodology are needed, including any adjustments needed for small providers. CMS stated that it agreed with GAO's recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-05-42.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Laura A. Dummit at (202) 512-7119.

MEDICARE HOSPICE CARE

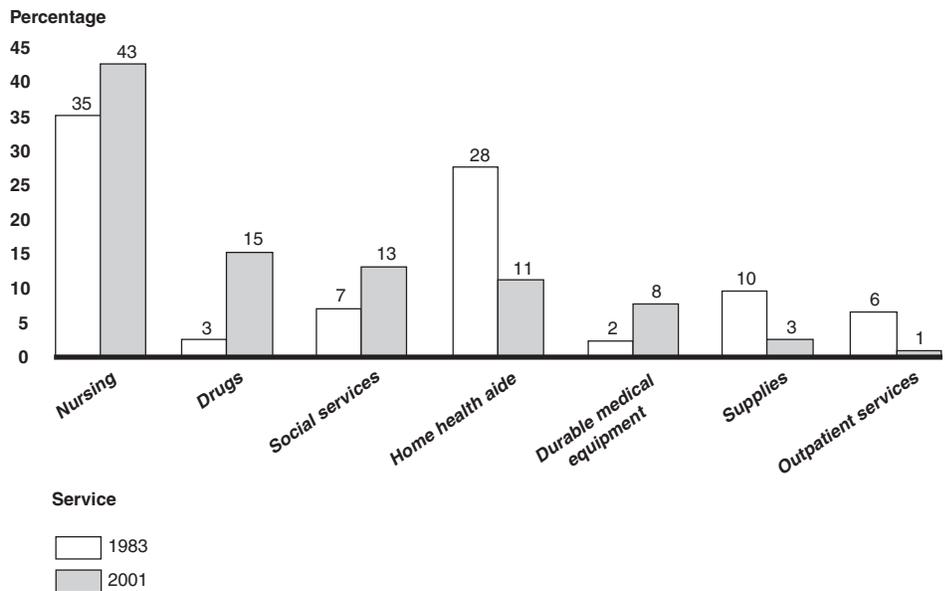
Modifications to Payment Methodology May Be Warranted

What GAO Found

Using Medicare cost reports from freestanding hospices, GAO determined that the per diem payment rate for all hospice care was about 8 percent higher than the estimated average per diem cost of providing care in 2000, and over 10 percent higher in 2001. However, the relationship between payment rates and costs varied across the payment categories and types of hospices. For all hospice care provided in the home, which accounted for about 97 percent of care in 2001, GAO estimates that the per diem payment rate was almost 10 percent higher than average per diem costs in 2000, and over 12 percent higher in 2001. Small hospices, however, had higher estimated average per diem costs than medium or large hospices overall and for each of the four per diem payment categories in 2001.

GAO's analysis indicates that the hospice payment methodology, with rates based on the historical mix and cost of services, a per diem amount that varies only by payment category, and a cap on total Medicare payments, may not reflect current patterns of care. For example, GAO determined that the relative costs of services, such as nursing care, provided during routine home care (RHC) have changed considerably since the rates were calculated. Using limited patient-specific hospice visit data, GAO found that more visits were provided during the first, and especially last, week of a hospice stay than during other times in the stay. Finally, few hospices reached the payment cap, which was intended to limit Medicare hospice spending.

Costs of Services Provided During RHC as a Percentage of Total RHC Costs, 1983 and 2001



Sources: GAO analysis of CMS data and 1983 hospice final rule (48 Fed. Reg. 56,008 (1983)).

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Abbreviations

BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
CHC	continuous home care
CMS	Centers for Medicare & Medicaid Services
DME	durable medical equipment
GIC	general inpatient care
HAA	Hospice Association of America
HCFA	Health Care Financing Administration
IRC	inpatient respite care
NHPCO	National Hospice and Palliative Care Organization
RHC	routine home care
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982

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United States Government Accountability Office
Washington, DC 20548

October 15, 2004

The Honorable Charles E. Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable William M. Thomas
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

Since the Medicare hospice benefit was implemented in 1983,¹ neither the payment methodology nor the payment rates for hospices have been evaluated; however, there are indications that hospice services and patients have changed. The payment methodology and rates for the benefit were developed using cost data collected from 26 hospices providing care to Medicare patients with terminal cancer under a 1980 to 1982 Health Care Financing Administration (HCFA)² demonstration. Since then, advances in medical technology, such as new palliative drugs, chemotherapy, and radiation, have influenced the mix of hospice services provided. In addition, the mean length of a hospice stay has declined since 1983, and the number of patients with noncancer diagnoses has grown considerably, representing approximately one-half of all patients receiving hospice care in 2000.

In addition to changes in the delivery of hospice care, there has been substantial growth in the hospice program. From 1992 through 2002, Medicare payments for hospice care increased fivefold, to about

¹Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, § 122, 96 Stat. 324, 356.

²In July 2001, the name of the agency that administers Medicare, HCFA, was changed to the Centers for Medicare & Medicaid Services. In this report, we refer to the agency as HCFA when discussing actions it took under that name.

\$4.5 billion, and the number of Medicare patients increased fourfold, to approximately 640,000. During the same period, the number of Medicare-participating hospices grew by almost 90 percent to 2,275.

The Medicare hospice benefit was designed to provide patients who have a terminal illness with comfort and pain relief, as well as emotional and spiritual support, generally in a home setting. By law, Medicare hospice services include nursing care, counseling, and home health aide services, as well as drugs and medical supplies.³ Hospice services are delivered by providers that operate as freestanding entities or are based in hospitals, home health agencies, or skilled nursing facilities. Under the law, Medicare pays hospices a daily rate⁴ that covers all services provided to the patient, except for physician services.⁵ HCFA developed four payment categories, with corresponding per diem payment rates to reflect variation in service intensity and the location of service.⁶ These categories, as set out in Medicare regulations, are routine home care (RHC), a typical day of home care; continuous home care (CHC),⁷ home care that is provided during periods of patient crisis for at least 8 hours in a 24-hour period; inpatient respite care (IRC), care in an inpatient facility for a short period to provide respite for primary caregivers; and general inpatient care (GIC), inpatient care to treat symptoms that cannot be managed in other settings. In 1986, annual updates to the rates for the four payment categories were set in law.⁸ A hospice is paid for each day that a patient is under its care, regardless of whether the patient receives a visit or other service on that day. Medicare pays the RHC payment category rate for days when a patient does not receive CHC, IRC, or GIC. In 2001, RHC days accounted for 96 percent of all days provided to hospice patients. By law, each hospice is subject to an aggregate payment cap,⁹ which limits its total

³42 U.S.C. § 1395x(dd)(1) (2000).

⁴42 U.S.C. § 1395f(i)(1)(B) (2000).

⁵Medicare pays physicians separately for services provided to hospice patients.

⁶42 C.F.R. § 418.302(b)(1) – (4) (2003).

⁷Although a per diem rate for CHC is determined, Medicare pays hospices an hourly rate for CHC calculated from the per diem rate.

⁸Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9123, 100 Stat. 82, 168 (1986).

⁹42 U.S.C. § 1395f(i)(2) (2000).

annual Medicare payments to a specified amount based on the number of Medicare patients it served.

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) directed us to study the feasibility and advisability of updating Medicare's payment rates for hospice care.¹⁰ Specifically, we (1) compared hospices' costs to the Medicare payment rates and (2) evaluated the appropriateness of the per diem payment methodology.

To compare hospices' costs to Medicare payment rates, we used 2000 and 2001 Medicare hospice cost reports, the most recent data available at the time of our analysis. We confined our analysis to cost reports of freestanding hospices.¹¹ Hospital-based and home health agency-based hospices must allocate overhead costs between the hospice and the hospital or home health agency, which may distort the costs of providing hospice services.¹² For freestanding hospices, the only costs incurred are for delivering hospice care to patients. We verified the reliability of the cost report data by comparing descriptive statistics calculated using the cost reports with those calculated using the Medicare hospice claims for all hospices from the same years, and we verified the reliability of the claims data by comparing descriptive statistics we calculated using the claims with statistics published by the Centers for Medicare & Medicaid Services (CMS). We excluded certain cost reports; for example, those with fewer than 11 total patients or an average of less than 1 patient per day. We determined the remaining data were suitable for our purposes. For freestanding hospices, we estimated average per diem costs by summing the total costs for all hospices and dividing by the total number of days of care for all hospices. We compared the estimated average per diem cost for freestanding hospices to an unadjusted payment rate based on national payment rates for each category.¹³ We also determined average per diem costs for each payment category using the same methodology and compared each to the unadjusted payment rate calculated for that

¹⁰Pub. L. No. 106-113, App. F, § 132, 113 Stat. 1501A-321, 1501A-333.

¹¹In 2001, over half of all Medicare hospice patients were served by freestanding hospices.

¹²Estimated per diem costs for these hospices were generally much lower than those of freestanding hospices.

¹³To calculate a single unadjusted hospice payment rate, we weighted the four rates by their respective utilization as reported on freestanding hospice cost reports in each year, accounting for the annual October 1 update in the payment rates.

category. Because RHC and CHC costs are reported in aggregate on the hospice cost report, we could only report hospices' average combined RHC and CHC per diem costs.¹⁴ We refer to combined RHC and CHC hospice costs and payment rates as home care costs and payment rates. Because of data limitations in the Medicare hospice cost report and claims data, we could not compare actual payments to costs.¹⁵ We did not apply the wage adjustment, which generally adjusts payments up for urban areas and down for rural areas to account for geographic differences in wages, to the payment rates. We estimated per diem costs for all freestanding hospices; for freestanding hospices of different sizes, with size defined by the number of days of care a hospice provided during the year; and for rural and urban freestanding hospices.¹⁶

To evaluate the appropriateness of the per diem payment methodology, we compared the proportion of total costs attributable to different services provided during RHC days when the payment rate was first determined, in 1983, to the proportion in 2001. We used the 2001 freestanding hospice cost reports to calculate proportions of cost for 2001. Our estimates of RHC costs in 2001 include CHC costs because RHC and CHC costs are reported in aggregate on the hospice cost report.¹⁷ Using 2002 proprietary data on patient visits collected by a large, for-profit hospice with multiple freestanding facilities, which we refer to as patient-specific visit data, we analyzed the types of visits provided to patients over the course of their hospice stays. We used these proprietary data because Medicare hospice cost reports and claims do not contain information on the visits hospices provide to Medicare patients each day. We confirmed that the distribution of visits in 2002 was consistent with the distribution in 1997 and 1999 for this hospice. We also calculated descriptive statistics for this hospice and

¹⁴To calculate an unadjusted payment rate that encompassed RHC and CHC, we weighted the individual rates of these two categories by their respective utilization as reported on freestanding hospice cost reports in each year.

¹⁵Unlike for other providers, Medicare's hospice cost reports do not include Medicare payment information. In addition, Medicare hospice claims contain only the total payment for all services provided during the billing period, including physician services, not the payment for each hospice payment category.

¹⁶We define a hospice as urban if it was located in a county that was in a metropolitan statistical area and as rural if it was located in a county outside a metropolitan statistical area, as determined by the Office of Management and Budget as of June 30, 1999.

¹⁷It is likely that CHC costs were a very small proportion of home care costs, as CHC days accounted for just over 1 percent of total hospice days in 2001. We refer to proportions of combined RHC and CHC costs as proportions of RHC costs.

compared them to statistics calculated using the Medicare hospice claims. We determined these data were suitable for our purposes. We interviewed officials at CMS, two national hospice associations, 18 hospices and several national independent and academic hospice researchers, and we conducted a site visit to a freestanding hospice with an inpatient unit. Our methodology is detailed in appendix I. We did our work from January 2003 through October 2004 in accordance with generally accepted government auditing standards.

Results in Brief

We determined that for freestanding hospices, the unadjusted per diem payment rate across the four payment categories was about 8 percent higher than estimated average per diem costs in 2000, and over 10 percent higher in 2001. We estimate that the home care (RHC and CHC) per diem payment rate was almost 10 percent higher than average home care per diem costs in 2000, and over 12 percent higher in 2001. The IRC payment rate was almost 53 percent lower than average IRC per diem costs in 2000, and 61 percent lower in 2001. In both years, the GIC payment rate was about 7 percent higher than average GIC per diem costs. We could not compare actual payments to costs because of limitations in the hospice cost report and claims data. In 2000, we estimate that average per diem costs for small freestanding hospices were over 13 percent higher than for medium freestanding hospices and almost 7 percent higher than for large freestanding hospices. In 2001, average per diem costs for small freestanding hospices were over 15 percent higher than for medium freestanding hospices and almost 8 percent higher than for large freestanding hospices. With the exception of average GIC per diem costs in 2000, small freestanding hospices had higher per diem costs for each payment category in both years. Small freestanding hospices are more likely than other hospices to be located in rural areas, and thus are more likely to receive lower Medicare payments because the wage index adjustment generally reduces the payments for providers in rural areas.

Several aspects of the hospice per diem payment methodology may not reflect how hospices currently deliver services. For freestanding hospices, the share of total costs accounted for by various services provided during RHC days was considerably different in 2001 than when the rates were developed in 1983. This suggests that the services delivered or the resources necessary for those services have changed. The proportions of RHC costs attributable to nursing, social services, drugs, and medical equipment have increased, while the proportions attributable to home health aide services, supplies, and outpatient services have decreased. In addition, our analysis of proprietary 2002 patient-specific visit data

showed that visit frequency varied during the hospice stay, yet the payment rates remain the same throughout the stay for each payment category. Also, the mean length of stay has decreased. Additionally, hospice officials told us that some CHC and IRC payment policy requirements limited their ability to deliver services, although data were not available to determine whether these requirements influenced the delivery of care to hospice patients. Finally, the annual aggregate cap was intended to help limit Medicare hospice spending, but the cap amount was not based on actual hospice costs, and for each year from 1999 through 2002, few hospices reached it.

We recommend that the Administrator of CMS collect comprehensive, patient-specific data on the utilization and cost of hospice visits and services. Using these data, the Administrator should determine whether the hospice payment methodology and payment categories need modifications, including any special adjustments for small providers. The Administrator should implement modifications that would not require a change in Medicare law, and submit a legislative proposal to the Congress for those that do. In commenting on a draft of this report, CMS stated that it agreed with our recommendations and intends to use our findings to supplement and reinforce preliminary evaluations the agency has made and future studies that are planned. In responding to our recommendation that it collect comprehensive, patient-specific data on hospice visits and services and the costs of these services and reevaluate the payment methodology, CMS stated that it recognized the need for these types of analyses but that its research funding is limited. In its comments, CMS also stated that it believed additional information is needed before modifying the payment methodology because of the higher average costs of small hospices. We have clarified our conclusion to indicate the need for comprehensive, patient-specific data on the visits and services delivered by hospices and the costs of these services to inform any changes to the payment methodology. Industry representatives who reviewed a copy of this draft generally agreed with our findings and recommendations.

Background

Medicare hospice benefit services include nursing services, services provided by a physician to a hospice, drugs and medical supplies necessary for treating pain and other symptoms of a terminal illness, as well as dietary, spiritual, and bereavement counseling; medical social worker services; homemaker services; and short-term inpatient care both to provide respite for caregivers and to treat a patient's symptoms. Volunteers are an important resource in delivering hospice care; Medicare requires each hospice to have volunteers provide services equal to at least

5 percent of the total paid patient care hours.¹⁸ The specific services that a patient should receive are outlined in a plan of care, vary based on the type and intensity of the patient's symptoms and psychosocial needs and the needs of the patient's caregiver, and may vary throughout the hospice stay as the patient's condition changes.

Hospice Eligibility

To be eligible for the Medicare hospice benefit, a patient must be certified by a physician as having a life expectancy of 6 months or less if his or her terminal illness runs its normal course. A Medicare patient who elects hospice care must waive Medicare coverage for all other services related to the terminal illness, although the patient retains coverage for services to treat other conditions. A patient may opt out of the hospice benefit and return to traditional Medicare at any time; a patient may also reelect hospice coverage at a later date. While there is no limit on the number of days an individual can receive hospice care, the prognosis of the patient's terminal illness must be reaffirmed after the first 90 days, the first 180 days, and then every 60 days thereafter.

Medicare Hospice Payment

Under the law, Medicare pays hospices a daily rate that covers all services provided to the patient. HCFA developed four hospice per diem payment categories, which reflect the intensity of the services and the location of service delivery. In 1986, annual updates to the rates for the four payment categories were set in law. A typical day of care provided in a patient's residence is paid as RHC, and in 2001, the vast majority of hospice care days, 96 percent, were billed as RHC (see table 1). Unless a hospice provides CHC, IRC, or GIC, it is paid the RHC rate for each day the patient is under its care. Hospice care delivered during periods of crisis can be paid as CHC if the care is provided in the home for at least 8 hours within a 24-hour period beginning at midnight and at least half the care hours are delivered by a nurse. To provide respite for primary caregivers, IRC can be provided for up to 5 consecutive days in an inpatient setting. Inpatient care for symptoms that cannot be treated in the patient's residence is paid as GIC. Hospices provide the care in their own inpatient units or arrange with hospitals, skilled nursing facilities, or other inpatient facilities to provide these services. The payment rate is adjusted by a wage index, which varies based on the patient's residence, to account for geographic differences in wage costs.

¹⁸ 42 C.F.R. § 418.70(e) (2003).

Table 1: Utilization and Payment Rates for Each Hospice Payment Category

Payment category	Percentage of total hospice days, 2001	Payment rate, 2004
RHC	96.0	\$118.08/day
CHC	1.2	\$28.72/hr, up to \$689.18/day
IRC	0.2	\$122.15/day
GIC	2.6	\$525.28/day

Source: GAO analysis of CMS data and Medicare payment rates.

The hospice payment categories and their corresponding payment rates were developed from cost data from the 26 hospices that participated in the 1980 to 1982 Medicare demonstration. To calculate the payment rates, HCFA used cost data to identify the cost factors that contributed to providing hospice services and summed the mean cost per day of each cost factor for each of the four categories of hospice care. The costs of bereavement and volunteer services were not included in the rates.¹⁹

By law, hospices are subject to an annual aggregate Medicare payment cap that was meant to ensure that payments for hospice care would not exceed what Medicare would have paid if patients had been treated in a traditional setting, such as a hospital.²⁰ Total annual payments to a hospice may not exceed a per-patient amount multiplied by the number of Medicare patients who received care from that hospice during the year. The 2004 cap amount for the 12 months beginning November 1, 2003, is \$19,635.67 per Medicare patient.²¹

¹⁹By statute, hospices must provide bereavement counseling, although Medicare is prohibited from paying hospices for such services (42 U.S.C. §§ 1395x(dd)(1)(H), 1395x(dd)(2)(A)(i), and 1395f(i)(1)(A) (2000)). The statute also specifies that hospices must use volunteers in the provision of care (42 U.S.C. § 1395x(dd)(2)(E)(i) (2000)). HCFA, however, did not include volunteer costs (such as volunteer training and program coordination costs) in setting the payment rates.

²⁰42 U.S.C. § 1395f(i)(2) (2000).

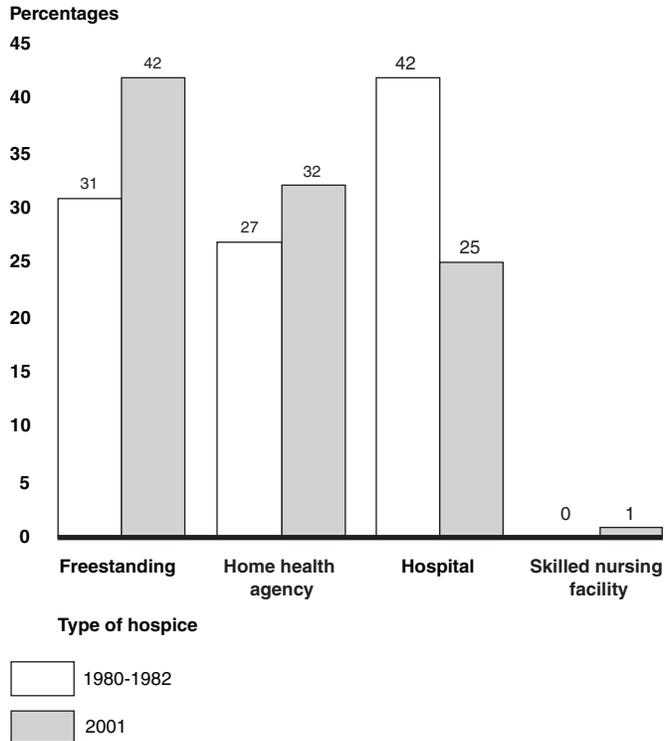
²¹Each year, the cap amount is updated by the annual percentage change in the medical care component of the Consumer Price Index for all urban consumers.

Changes in Hospice Care

Hospice patients, services, and providers have changed since the demonstration. For example, the mean patient length of stay at hospices participating in the Medicare demonstration from 1980 to 1982, was 70 days; in 2001, the mean length of stay was about 50 days. While demonstration costs were based only on Medicare patients with cancer diagnoses, patients with noncancer diagnoses, who may require a different mix of services, represented approximately half of all hospice patients in 2000. In addition, hospice providers have stated that advances in end-of-life care, notably new, more costly pain-management drugs and palliative chemotherapy and radiation, have increased the costs of providing care to certain types of patients.

The mix of hospice providers today differs from the provider types in the demonstration. In the demonstration, the predominant type of hospice provider was hospital-based, whereas in 2001, the predominant type was freestanding (see fig. 1). More recently, the proportion of for-profit hospices increased from almost 13 percent of all hospices in 1992 to almost 28 percent in 2001, and the percentage of hospices serving patients primarily living in rural areas rose from 32 in 1992 to 38 in 2001. In addition, the number of hospices participating in Medicare grew from 1,208 in 1992 to 2,275 in 2002, the most recent data available.

Figure 1: Hospice Provider Types Participating in the 1980-1982 Demonstration and in 2001 (Percentages)



Sources: 66 Fed. Reg. 49,454 (2001) and Vincent Mor, David S. Greer, and Robert Kastenbaum, *The Hospice Experiment* (Baltimore: The Johns Hopkins University Press, 1988), 33-34.

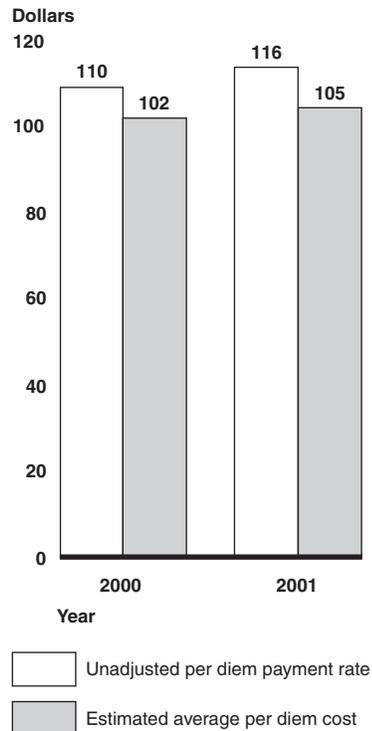
Overall Medicare Hospice Payment Rate Higher Than Freestanding Hospices' Estimated Average Costs, but Relationship Varied by Payment Category and Hospice Characteristics

We determined that for freestanding hospices, the unadjusted per diem payment rate across the four payment categories was about 8 percent higher than estimated average per diem costs in 2000, and over 10 percent higher in 2001. For the payment categories, we estimate that the home care (RHC and CHC) per diem payment rate was almost 10 percent higher than average home care per diem costs in 2000, and over 12 percent higher in 2001. We estimate that the IRC payment rate was almost 53 percent lower than average IRC per diem costs in 2000, and 61 percent lower in 2001. In both years, the GIC payment rate was about 7 percent higher than average GIC per diem costs. In 2000, we estimate that average per diem costs for small hospices were over 13 percent higher than for medium hospices and almost 7 percent higher than for large hospices. In 2001, average per diem costs for small hospices were over 15 percent higher than for medium hospices and almost 8 percent higher than for large hospices. With the exception of average GIC per diem costs in 2000, small hospices also had higher average per diem costs than medium or large hospices for each payment category.

Unadjusted Payment Rate Higher Than Freestanding Hospices' Estimated Average Costs

Medicare's hospice payment rate, across the four payment categories and unadjusted for geographic differences in wages, was higher than freestanding hospices' estimated average per diem cost. The unadjusted payment rate was about 8 percent higher than average per diem costs in 2000, and over 10 percent higher in 2001 (see fig. 2). The 25 percent of hospices with the lowest average per diem costs had costs that were at least 27 percent below the unadjusted payment rate in 2000, and at least 31 percent below the unadjusted payment rate in 2001. However, in 2000, average per diem costs for almost 34 percent of freestanding hospices and, in 2001, almost 32 percent of freestanding hospices, were higher than the unadjusted per diem rate. The costs of individual hospices differ depending on the mix of services provided. In addition, the payments to individual hospices differ because of the wage adjustment and the mix of payment categories billed.

Figure 2: Unadjusted Per Diem Payment Rate and Estimated Average Per Diem Costs for Freestanding Hospices, 2000 and 2001



Sources: GAO analysis of CMS data and Medicare hospice payment rates.

Note: The unadjusted payment rate equals the rates of the four payment categories weighted by their respective utilization as reported in freestanding hospice cost reports in each year, accounting for the annual October 1 update in the payment rates.

We could not determine the relationship between payments and actual costs for individual hospices because of data limitations in the hospice cost reports and claims data. Unlike those for other providers, Medicare's hospice cost reports do not include Medicare payment information. In addition, Medicare hospice claims data contain only the total payment for all services provided during the billing period, including physician services, not the payment for each hospice payment category.

**Relationship between
Estimated Costs and
Unadjusted Payment Rates
Varied among Payment
Categories**

The specific relationship between payment rates and costs for freestanding hospices varied among payment categories. For home care (RHC and CHC) days, we estimate that in 2000, the unadjusted per diem payment rate for freestanding hospices was almost 10 percent higher than the average per diem cost of over \$92. In 2001, the per diem payment rate was over 12 percent higher than the average home care per diem cost of over \$96. Nonetheless, about 35 percent of freestanding hospices in 2000, and over 32 percent in 2001, had average home care per diem costs that were higher than the home care per diem payment rate.

We estimate that in 2000, the unadjusted IRC per diem payment rate for freestanding hospices was almost 53 percent lower than the average IRC per diem cost of about \$218. In 2001, the IRC per diem payment rate was over 61 percent lower than the average IRC per diem cost of over \$279. However, the GIC per diem payment rate was higher than average GIC per diem costs for freestanding hospices; it was over 7 percent higher than costs in both years. In addition, average per diem costs for IRC and GIC varied widely among freestanding hospices. Our estimates of average IRC and GIC per diem costs may understate actual costs because of data limitations.

IRC costs may be much higher than the IRC payment rate because the hospice continues to provide services and visits to the patient in addition to paying the inpatient facility.²² Our analysis of the proprietary 2002 patient-specific visit data found that the number and type of visits provided per day to patients during IRC days were comparable to the number and type of visits per day to patients during RHC days. In 2001, IRC accounted for 0.2 percent of hospice days of care.

²²During GIC, hospices also provide services and visits to the patient in addition to paying the inpatient facility.

Small Hospices Had Higher Per Diem Costs and Likely Lower Payments

We estimate that for 2000 and 2001, small freestanding hospices had higher average per diem costs than medium and large freestanding hospices.²³ In 2000, average per diem costs for small hospices were more than 13 percent higher than for medium hospices and almost 7 percent higher than for large hospices. In 2001, average per diem costs for small hospices were more than 15 percent higher than for medium hospices and almost 8 percent higher than for large hospices (see table 2). With the exception of average GIC per diem costs in 2000, small hospices' average per diem costs were higher than medium and large hospices' costs for each individual payment category for both years. Cost disparities across providers of different sizes were greatest for IRC and GIC.

Table 2: Estimated Average Per Diem Costs by Payment Category for Freestanding Hospices, by Size, 2001

Hospice size	Average costs	Home care average costs ^a	IRC average costs	GIC average costs
Small	\$116	\$112	\$692	\$564
Medium	101	94	254	460
Large	108	96	264	420

Source: GAO analysis of CMS data.

Notes: The size of the hospice is based on the number of days of care it provided during the year. Small hospices were those that reported total days of care less than the 25th percentile of all hospices' total days of care. Medium hospices were those that reported total days of care equal to or greater than the 25th percentile and less than or equal to the 75th percentile of all hospices' total days of care. Large hospices were those that reported total days of care greater than the 75th percentile of all hospices' total days of care.

^aHome care costs include RHC and CHC costs.

As small freestanding hospices are more likely than other hospices to be located in rural areas, they are more likely to receive lower Medicare payments because the wage index adjustment generally reduces the payment rates for providers in rural areas. In 2001, 60 percent of small freestanding hospices were located in rural areas, while 35 percent of

²³The size of the hospice in each year is based on the number of days of care it provided that year. Small hospices were those that reported total days of care less than the 25th percentile of all hospices' total days of care. Medium hospices were those that reported total days of care equal to or greater than the 25th percentile and less than or equal to the 75th percentile of all hospices' total days of care. Large hospices were those that reported total days of care greater than the 75th percentile of all hospices' total days of care.

medium freestanding hospices and 10 percent of large freestanding hospices were located in rural areas.²⁴

Structure of Hospice Payment Methodology May Not Be Consistent with Current Service Delivery

The structure of the hospice payment system may not reflect how hospices currently deliver services. For example, our analysis of the relative costs for freestanding hospices for different services provided during RHC days, the most common payment category, showed they have changed considerably since the payment rate was initially calculated, suggesting that the services delivered or the resources necessary for those services have changed over the years. In addition, our analysis of proprietary 2002 patient-specific visit data showed that visit frequency varied during the hospice stay, although the rate for each payment category does not. Also, the mean length of stay has decreased. Hospice officials raised concerns about some of the payment policy requirements for CHC and IRC, although our analysis of the limited available data could not confirm that the requirements restrict hospices' ability to provide care. Finally, the annual aggregate cap was intended to help limit Medicare spending for all hospices, but it was not based on actual hospice costs, and for each year from 1999 through 2002, few hospices reached it.

Relative Costs of Services Provided during RHC Differ from When Payment Rate Was Developed

The relative costs of services in 2001 have changed considerably since the payment rate was developed in 1983, suggesting that the services delivered or the resources necessary for those services have changed over time. Specifically, the proportions of RHC costs attributable to nursing, drugs, social services, and durable medical equipment (DME)²⁵ have increased, while the proportions attributable to home health aide services, supplies, and outpatient services have decreased (see fig. 3).²⁶ In our analysis, this pattern is present across freestanding hospices of all sizes and locations. The largest cost increase occurred for drugs, which rose from 3 to 15 percent of RHC costs over this period. Hospice officials we spoke with

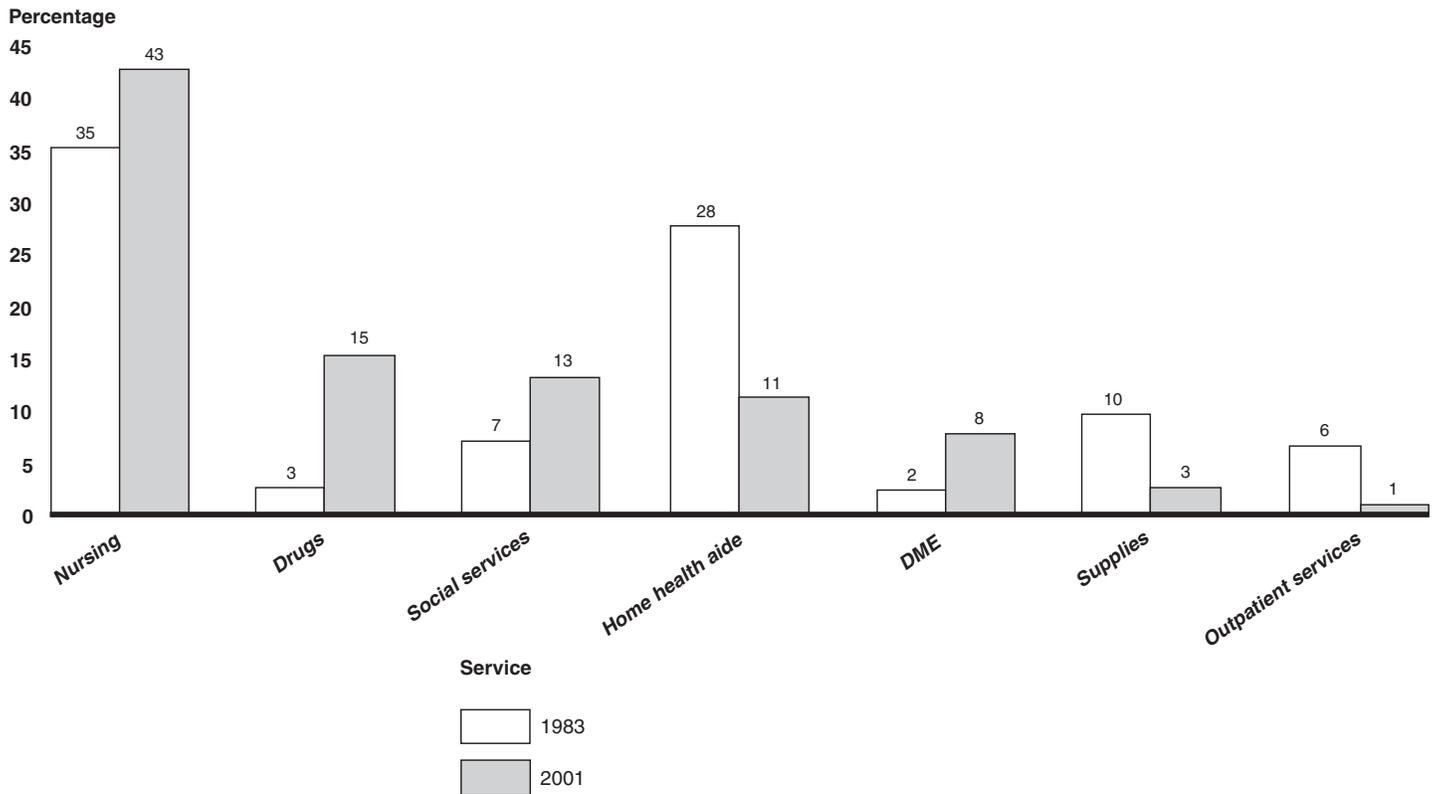
²⁴While urban freestanding hospices also had higher estimated average per diem costs compared to rural freestanding hospices in our analysis, urban hospices generally receive higher payments than rural hospices to account for the higher wages they must pay.

²⁵DME is equipment prescribed by a physician for the medical purpose of addressing a patient's illness or injury that can withstand repeated use, such as respirators, crutches, and oxygen equipment.

²⁶RHC costs for 2001 are slightly overestimated, as they include CHC costs. CHC days accounted for just over 1 percent of total hospice days in 2001.

stated that this increase was due in part to the introduction of new, more costly medications. Some stated that drugs have become one of their greatest cost pressures.

Figure 3: Costs of Services Provided during RHC as a Percentage of Total RHC Costs, 1983 and 2001



Sources: GAO analysis of CMS data and 1983 hospice final rule (48 Fed. Reg. 56,008 (1983)).

Notes: Percentages from 1983 are based on cost data collected in the 1980 to 1982 hospice demonstration. RHC costs for 2001 are slightly overestimated, as they include CHC costs. CHC days accounted for just over 1 percent of total hospice days in 2001.

Fewer Days of Lower Visit Frequency with Shorter Mean Length of Stay

Hospice visits are particularly concentrated at the beginning and end of a hospice stay, yet the payment rate of each category does not vary throughout a hospice stay. Our analysis of the 2002 patient-specific visit data showed that patients have a higher mean number of visits per day

during the first, and especially the last, week of a stay.²⁷ As a result, the costs of care are higher both at the beginning and end of a hospice stay. Officials from almost all hospices with whom we spoke also reported this pattern. They told us that at the beginning of a hospice stay they provide more visits because the patient's symptoms, including pain, must be stabilized and the family must be educated about the patient's care. Near the end of life, hospice officials indicated that the patient's symptoms and needs change, usually requiring more hospice management, and the family often needs additional psychosocial support. Our analysis of the 2002 patient-specific visit data showed that patients with a length of stay of 2 weeks or less had a higher mean number of visits per day than patients with a length of stay greater than 2 weeks.²⁸ Hospice officials we spoke with stated that patients who are in hospice care a short time are relatively more costly on a per diem basis because there are fewer days of lower visit frequency to balance the higher costs of the days with more visits at the beginning and end of the stay.

In 1983, the Medicare hospice per diem payment amounts accounted for the variation in daily hospice costs because they were based on the mean daily costs incurred by the hospices in the demonstration over a mean hospice stay of 70 days. However, hospice stays are considerably shorter now; the mean length of stay was 50 days in 2001. Mean daily costs may now be very different because of the change in the length of stay. No data are available, however, to compare costs at different points during a stay or for stays of different lengths.

Providers Raised Concerns about Payment Category Requirements

Hospice officials we spoke with raised concerns about some of the policy requirements for particular payment categories, although our analysis of the available data could not confirm their concerns. For example, to bill for CHC, Medicare requires that a nurse provide at least half of billed CHC

²⁷We also analyzed patient visit frequency by certain patient characteristics. Using 2002 patient-specific visit data, we found no substantial differences in the mean number of visits per day among patients of different ages, diagnoses, numbers of secondary conditions, or residential locations. (The patient-specific visit data categorized patients as residing in their home, a nursing home, an assisted living facility, or a hospital. In this analysis, patients residing in a hospital had a slightly lower mean number of visits per day than patients residing in other locations.)

²⁸We also found that patients with a length of stay of 2 weeks or less had a higher proportion of CHC days, representing the delivery of more intensive, and therefore more costly, services, compared to patients with longer stays.

hours. Hospice officials stated that this could restrict the hospice's ability to provide the most appropriate care when a social worker was a more appropriate caregiver than a nurse.

The officials were also concerned that the 8-hour minimum required for billing CHC payment, counted from midnight of one day until midnight of the next, could restrict their ability to bill for CHC. For example, if a patient dies in less than 8 hours or the hospice provides 8 hours of services over 2 calendar days, the hospice must bill for RHC. Our analysis of 2001 Medicare hospice claims indicated that the mean number of hours provided on a CHC day was 18 hours, considerably above the 8-hour minimum. Similarly, our analysis of the 2002 patient-specific visit data from one large, freestanding hospice showed a mean of 20 hours provided on each CHC day. Therefore, instances of continuous care hours that fall just short of 8 hours, for which a hospice cannot bill CHC hours, do not occur often based on the patient-specific visit and claims data.

Hospice officials we spoke with also stated that the statutory requirement that respite care be provided in an inpatient setting might hinder its use.²⁹ Specifically, they stated that while primary caregiver respite is important, enabling patients to remain at home rather than moving them to an inpatient facility is also important; primary caregivers may not take respite in order to avoid moving the patient to an inpatient facility. Few hospices we spoke with currently provide home respite care for extended periods. They said this is largely because the costs are higher than the RHC payment rate, which is the payment category the hospices must bill for these services. Data related to home respite care are not available, although it is likely that the costs of providing 24 hours of home respite care would be higher than RHC costs.

Few Hospices Affected by Annual Aggregate Cap

According to our analysis of data from the regional home health intermediaries, the contractors responsible for processing and paying Medicare hospice claims, less than 2 percent of all hospice providers reached the annual aggregate payment cap each year from 1999 through 2002.³⁰ In 1982, the Congress required HCFA to calculate a cap that limited

²⁹42 U.S.C. 1395x(dd)(1)(G) (2000).

³⁰One regional home health intermediary had jurisdiction over at least 71 percent of the hospices that reached the cap each year from 1999 through 2002. This intermediary had no additional information on why these hospices reached the cap.

a hospice's total payments to a specific per-patient amount based on the Medicare costs incurred for patients with cancer during the last 6 months of life.³¹ However, a subsequent law enacted before the hospice benefit was implemented set a per-patient cap amount that was not based on the cost data;³² for the 12 months beginning November 1, 2003, the cap was \$19,635.67 per Medicare patient. The cap is intended to ensure that payments for hospice care do not exceed what Medicare would have spent if patients had been treated in a traditional setting, such as a hospital. However, it affects few hospices, and therefore may not represent a meaningful limit. Hospice officials we spoke with who discussed the cap said it did not affect them.

Conclusions

CMS has not evaluated the hospice per diem payment rates and methodology since they were developed to determine the relationship between payments and costs and whether the per diem methodology is consistent with current patterns of care. There are several indications that hospice payments may not be appropriately distributed across days of care or types of providers. The type of care provided during a hospice stay appears to be different than when the hospice per diem payment rates and methodology were developed. Comprehensive data are not available, however, to evaluate the number of visits or costs of services provided during a Medicare hospice stay. While our analysis of the limited data available indicates that the overall Medicare payment rate across all payment categories was above estimated costs, IRC costs were considerably above the payment rate. Further, small freestanding hospices had substantially higher average per diem costs than other hospices. As a result, a comprehensive analysis of patient-specific data may show that modifications to the hospice payment methodology are warranted. Because the payment rates for the four hospice payment categories, the per diem methodology, and the cap are set by law, CMS's ability to make modifications to the payment approach is limited.

³¹TEFRA, § 122(i)(1), 96 Stat. 358-359.

³²42 U.S.C. § 1395f(i)(2) (2000).

Recommendations for Executive Action

We recommend the following three actions. First, we recommend that the Administrator of CMS collect comprehensive, patient-specific data on the visits and services being delivered by hospices and the costs of these services. Second, using these data, the Administrator should determine whether the hospice payment methodology and payment categories need to be modified, including any special adjustments for small providers. Third, the Administrator should implement those modifications that would not require a change in Medicare law and submit a legislative proposal to the Congress for those that do.

Agency and External Reviewer Comments and Our Evaluation

We received written comments on a draft of this report from CMS (see app. II). We also received oral comments from two groups representing industry organizations, the Hospice Association of American (HAA) and the National Hospice and Palliative Care Organization (NHPCO), as well as from the large, for-profit hospice that provided the patient-specific visit data.

CMS Comments and Our Evaluation

In commenting on a draft of this report, CMS stated that it agreed with our recommendations and intends to use our findings to supplement and reinforce preliminary evaluations the agency has made and future studies that are planned. In responding to our recommendation that it collect comprehensive, patient-specific data on hospice visits and services and the costs of these services, CMS stated that it recognized the need for this type of analysis. It stated that collection of these data would require additional research funding, and it is uncertain when such funding would be available. CMS noted that it has initiated efforts to collect data on costs with the recent establishment of the hospice cost reports. CMS stated that it hoped the recommendations in our report could help the agency in developing a comprehensive research strategy for the hospice benefit.

In responding to our recommendation that CMS determine whether the hospice payment methodology and payment categories need to be modified, including any adjustments for small providers, CMS agreed that the methodology implemented in 1983 was based on a delivery model that may have changed since that time. It concurred that the methodology should be reevaluated to determine its current appropriateness. It again stated that research funding is limited. CMS agreed that the costs of drugs and other therapies, the number of hospice beneficiaries with noncancer diagnoses, and the mean length of stay have all changed since 1983. CMS stated that we did not demonstrate in the draft report that the provision of these and other therapies have increased the cost of providing care beyond the present payment. In the draft report, we stated that there may

be problems with the distribution of hospice payments, but that comprehensive data are not available to evaluate the number of visits or costs of services provided during a Medicare hospice stay. As noted in the draft report, the overall payment rate across all types of care is higher than our estimate of hospices' overall costs. In its comments, CMS also raised concerns that we implied that payment methodology changes be made for small hospices before CMS collects comprehensive data. We have clarified our conclusion to indicate the need for comprehensive, patient-specific data on the visits and services delivered by hospices and the costs of these services to inform any changes to the payment methodology.

In response to our recommendation that CMS should submit a legislative proposal to the Congress to implement those modifications that would require a change in Medicare law, CMS stated that should it determine changes are necessary, it would evaluate those changes as part of its overall legislative strategy.

CMS also made technical comments, which we incorporated where appropriate.

Industry Comments and Our Evaluation

The external reviewers generally agreed with our findings and recommendations. Comments on specific portions of the draft report centered on two areas: our scope and methodology and the hospice payment methodology.

Regarding our scope and methodology, HAA and NHPCO were concerned that we based our findings on Medicare freestanding hospice cost reports that had not been audited. The large, for-profit hospice noted that the cost report is complex and that hospices' accounting systems are not generally compatible with its structure. Similarly, HAA and NHPCO stated that hospices may not have had sufficient experience with completing the cost reports at the time of our review. NHPCO stated that our exclusion of hospice cost reports with fewer than 11 total patients or an average of less than 1 patient per day might have excluded a substantial number of cost reports. In addition, HAA and NHPCO recommended that we include bereavement counseling costs in our per diem cost calculation. They stated that although Medicare is precluded from paying hospices for bereavement counseling, it is a required service, and excluding it from the per diem cost calculation may misrepresent the amount by which payment rates exceeded hospice costs.

Regarding reviewers' concerns about our use of unaudited cost reports, BBRA directed us to examine hospice cost factors. Information on these factors is available only from cost reports, which CMS has not audited. As stated in the draft report, we assessed the reliability of the cost reports by comparing descriptive statistics calculated using the cost reports with those calculated using the Medicare hospice claims, and found the data suitable for our purposes. Regarding reviewers' concerns about data we excluded from our analysis, we excluded 51 of 992, or 5 percent, of freestanding hospice cost reports in 2000, and 48 of 975, or 5 percent, of freestanding hospice cost reports in 2001, because they had fewer than 11 total patients or an average of less than 1 patient per day. We excluded these cost reports because we believe that these hospices either had too few patients to be representative of all hospices, or may have been reporting data incorrectly. We do not believe that these represent substantial numbers of cost reports and consider our exclusion criteria appropriate. Concerning the comments that we should include bereavement costs in our per diem cost calculation, as stated in the draft report, we included only Medicare-reimbursable costs in our calculations. If Medicare cannot, by law, pay hospices for bereavement services, it is inappropriate to include them in a per diem cost that is compared to a payment rate that is not designed to cover these costs. In 2001, in comparison to total Medicare-reimbursable costs, bereavement costs were small; they were equal to less than 2 percent of total Medicare-reimbursable costs.

Reviewers also commented on the hospice payment methodology. NHPCO stated that costs on the cost report may not reflect the provision of all services that could potentially be provided because hospices may manage their costs to more closely approximate the per diem rate. Although the provision of additional services may be warranted, hospices cannot pay for them and therefore do not provide them. HAA and NHPCO stated that instances of CHC provision that fall close to 8 hours may not seem to occur often because hospices avoid providing CHC if they know they will not be able to provide at least 8 hours. However, HAA and NHPCO also stated that data to determine whether this is the case are not available.

Regarding industry comments on hospice costs and the hospice payment methodology, we acknowledge that hospices may manage their costs to closely approximate the per diem rate, and that hospices may not provide CHC if they know they will not be paid for that level of care. Data are not available to evaluate whether either of these situations occur.

Reviewers also made technical comments, which we incorporated where appropriate.

We are sending copies of this report to the Administrator of CMS and appropriate congressional committees. The report is available at no charge on GAO's Web site at <http://www.gao.gov>. We will also make copies available to others on request.

If you or your staffs have any questions, please call me at (202) 512-7119 or Nancy A. Edwards at (202) 512-3340. Other major contributors to this report include Beth Cameron Feldpush, Joanna L. Hiatt, and Gordon W. Richmond.



Laura A. Dummit
Director, Health Care—Medicare Payment Issues

Appendix I: Scope and Methodology

To examine hospice costs and Medicare payments, we used 2000 and 2001 Medicare hospice cost reports, the financial documents that hospices submit annually to the Centers for Medicare & Medicaid Services (CMS), and 2000 and 2001 Medicare hospice claims data, bills submitted by hospices to receive Medicare payment. We also used proprietary 2002 patient-specific visit data from a large for-profit hospice, which has been collecting these data for its internal use since 1994. We interviewed officials from CMS and one regional home health intermediary, a contractor responsible for processing and paying Medicare hospice claims, in addition to officials from AARP, the Hospice Association of America, the National Hospice and Palliative Care Organization, and the Visiting Nurse Associations of America. We also spoke with representatives from 18 hospices, several national independent and academic hospice researchers, and two physicians who provide hospice care. Finally, we conducted a site visit to a freestanding hospice with an inpatient unit.

To assess the reliability of the cost report data, we compared descriptive statistics calculated using the cost reports with those calculated using the Medicare hospice claims data. Because hospices began submitting cost reports in 1999, we also compared our calculations from the 2000 cost reports to those from the 2001 cost reports to ensure that hospices had provided consistent data. To assess the reliability of the claims data, we compared descriptive statistics calculated using the claims with statistics published by CMS. To assess the consistency of the 2002 patient-specific visit data, we verified that the distribution of visits in the 2002 data was similar to the distribution of visits in 1997 and 1999. In addition, before releasing these data to us, the hospice performed quality assurance edits, which consisted of confirming that the data provided to us were identical to the data in its database for more than 20 randomly selected patients. Finally, we calculated descriptive statistics and compared them with statistics for all hospices calculated using the Medicare hospice claims. We determined that the cost report, claims, and patient-specific data were all suitable for our purposes.

The 2000 and 2001 hospice cost reports were the most recent data available at the time of our analysis. The Medicare payment methodology is the same for freestanding and facility-based hospices; however, we confined our analysis to cost reports of freestanding hospices. We excluded hospital-based and home health agency-based hospices because we found that their per diem costs were generally much lower than those of freestanding hospices, which may result from decisions made by these providers in allocating overhead costs between the hospital or home health agency and the hospice. For freestanding hospices, the only costs

incurred are for delivering hospice care to patients. We excluded freestanding cost reports that reported no or low Medicare utilization, those that had cost reporting periods of fewer than 10 or greater than 14 months, and those outside the 50 states or District of Columbia. We also excluded cost reports that had fewer than 11 total patients or an average of less than 1 patient per day, those with no costs, and those reporting costs outside three standard deviations of the mean. Our final sample included 82 percent of all freestanding hospice cost reports in 2000 and 80 percent in 2001.

We calculated freestanding hospices' total Medicare-reimbursable costs by subtracting nonreimbursable costs, such as bereavement and fund-raising, from total costs. To obtain average per diem costs, we summed total Medicare-reimbursable costs across all providers and divided by total hospice days across all providers. In addition, because of the cost report design, certain inpatient respite care (IRC), general inpatient care (GIC), and physician costs may be included in our estimate of combined routine home care (RHC) and continuous home care (CHC), or home care, costs. As a result, home care costs may be overestimated, which would result in our understating the amount by which the unadjusted home care payment rate exceeds average home care per diem costs. Because of the way cost centers are defined on the cost reports, the costs of IRC and GIC may be underestimated.

We based the size of a hospice in each year on the number of days of care it provided that year. Small hospices were those that reported total days of care less than the 25th percentile of all hospices' total days of care. Medium hospices were those that reported total days of care equal to or greater than the 25th percentile and less than or equal to the 75th percentile of all hospices' total days of care. Large hospices were those that reported total days of care greater than the 75th percentile of all hospices' total days of care. We defined a hospice as urban if it was located in a county that was in a metropolitan statistical area and as rural if it was located in a county that was not in a metropolitan statistical area, as determined by the Office of Management and Budget as of June 30, 1999.

We could not compare the 2000 and 2001 per diem costs we calculated to actual payments because hospice cost reports do not report Medicare payment information. In addition, Medicare hospice claims contain only the total payment for all services provided during the billing period, including physician services, not the payment for each payment category. Therefore, we calculated a 2000 and 2001 unadjusted payment rate that

encompassed all payment categories. We did so by weighting the individual rates of the four payment categories by their respective utilization in the freestanding hospice cost reports in our final sample in each year. The costs for home care, combined RHC and CHC, are reported in aggregate on the hospice cost report. Therefore, we calculated a 2000 and 2001 unadjusted payment rate that encompassed RHC and CHC. We did so by weighting the individual rates of these two categories by their respective utilization in the freestanding hospice cost reports in our final sample in each year. In addition, we weighted the overall unadjusted payment rate and the unadjusted payment rate for each payment category to account for the different payment rates in effect during the year. The majority of freestanding hospices report costs using a calendar year reporting period, while payment rates are updated on a fiscal year basis, that is, on October 1 of each year. Therefore, during a calendar year, one payment rate is in effect from January 1 through September 30 and another from October 1 through December 31. Our unadjusted payment rates do not account for the wage adjustment Medicare applies to payments.

To determine the proportion of total cost in 2001 accounted for by each service, such as nursing or home health aide services, that was included in the 1983 RHC rate, we grouped the services on the cost report into categories similar to the 1983 services, and divided by the total cost. Our estimates of the proportions of 2001 RHC costs include CHC costs because the costs of RHC and CHC are reported in aggregate on the hospice cost report. It is likely that CHC costs were a very small proportion of combined RHC and CHC costs, as CHC days accounted for just over 1 percent of total hospice days in 2001.

To determine the percentage of total hospice days accounted for by each payment category and the mean CHC hours per CHC day for all hospices, we used 2000 and 2001 Medicare hospice claims data, the years that matched most closely with the cost reports used for our analysis. We excluded from our analysis patients who were younger than 20 or older than 110 years of age, who lived outside of the 50 states or the District of Columbia, and who had total hospice payments that fell below 1 day of care at the lowest wage-adjusted RHC payment rate and above 1 year of care at the highest wage-adjusted RHC payment rate. Our final sample included over 98 percent of all claims in both 2000 and 2001.

To analyze the frequency and types of visits to hospice patients, we used proprietary 2002 data on Medicare hospice patients collected by a large, for-profit hospice with multiple freestanding facilities. We determined the

number of visits per day and the number of nurse, home health aide, counselor, and other caregiver visits per day for all days and for days within each of the four payment categories. We also analyzed whether there were differences in the number of visits per day provided by patient length of stay, patient residence, diagnosis, number of secondary conditions, and age and determined the number of visits in the first and last week of a stay and for the remaining days of a stay.

We conducted our work from January 2003 through October 2004 in accordance with generally accepted government auditing standards.

Appendix II: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 15 2004

TO: Laura A. Dummit
Director, Health Care – Medicare Payment Issues
United States General Accountability Office

FROM: Mark B. McClellan, M.D., Ph. D.
Administrator 

SUBJECT: General Accountability Office's (GAO) Draft Report: *MEDICARE HOSPICE CARE: Modifications to Payment Methodology May Be Warranted* (GAO-04-794)

Thank you for the opportunity to review and comment on the draft report. We appreciate the interest of the Congressional Committees and the efforts of the GAO in the methodology used to determine Medicare hospice payment rates.

The payment methodology and rates for the Medicare hospice benefit were developed utilizing cost data from 26 hospices that were part of a demonstration project run by the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, from 1980 to 1982. At that time, patients receiving hospice care had a diagnosis of terminal cancer and received the hospice benefit for an average length of stay of 70 days. This methodology has not been systematically evaluated since the inception of the hospice benefit in 1983. The Balanced Budget Refinement Act of 1999 directed the GAO to study the hospice payment methodology and rates.

The CMS is committed in ensuring that Medicare beneficiaries receive current and appropriate hospice services and in providing the hospice agencies with remuneration for the services rendered while preserving the Medicare Trust Fund. We want to thoroughly evaluate what the cost for delivering these services are and to make the necessary modifications, if needed, to ensure that the triad of beneficiary/hospice/Medicare is in a partnership. The CMS intends to utilize the findings in this report to supplement and reinforce the preliminary evaluations that have occurred and future studies that are planned.

The CMS thanks the GAO staff for their effort and recommendations. We have enjoyed working with them through this process and hope to have further opportunities as we venture forward.

Attached are specific CMS' comments to GAO's recommendations.

Attachment

**Centers for Medicare & Medicaid Services' Comments to the GAO
Draft Report: *MEDICARE HOSPICE CARE: Modifications to Payment
Methodology May Be Warranted* (GAO-04-794)**

GAO Recommendation

CMS should collect comprehensive, patient-specific data on the visits and services being delivered by hospices and the costs of these services.

CMS Response

We concur with this recommendation and recognize the need for this type of analysis. The CMS recognizes the importance of monitoring the effects of payment changes and in improving and refining Medicare payment systems over time. An effort to collect comprehensive patient-specific data on visits and on the cost of services would require additional research funding. We have initiated efforts in this regard by establishing a cost report that provides basic data costs. With the competing demands for research funding, we have been unable to analyze this data. An even more costly research effort would be needed to conduct primary data collection on resource use on a patient basis. With the high priority research efforts needed to implement other prospective payment systems, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provisions, including a new drug benefit, we are uncertain when we would be able to fund this effort. We are hopeful that the recent analyses conducted by MedPac and the recommendations contained in this report will help guide us in developing a comprehensive research strategy for the Medicare hospice benefit.

GAO Recommendation

Using data collected, CMS should determine whether the hospice payment methodology and payment categories need to be modified, including any special adjustments for small providers.

CMS Response

We agree that the methodology employed in 1983 to develop the payment rates was based upon a delivery model that may have changed, to some extent, since that time. We concur that this methodology should be reevaluated to determine its appropriateness at this time. The CMS recognizes the importance of monitoring the effects of changes in the cost for delivering services as well as improving and refining Medicare payment systems over time. Once again, funding restrictions are a limitation. We are hopeful that the information contained in this report will help support the development of a comprehensive research strategy for the hospice benefit when funding is allocated to this effort.

The draft report identified factors that have emerged due to the changing nature of delivering hospice care, which may need to be reexamined. These included the cost of drugs and other

Page 2 - Attachment

therapies, the increase in the number of hospice beneficiaries with non-cancer diagnoses, and the change in average length of stay. The CMS agrees that beneficiaries with non-cancer diagnoses are increasingly electing the hospice benefit. We agree that the cost of some drugs may be more costly today. We also acknowledge that chemotherapy and radiation are used as palliative therapies today. However, this draft report does not demonstrate that the provision of these and other therapies have increased the cost of providing care beyond the aggregate payment that hospice agencies receive for each beneficiary.

In terms of average length of stay, CMS does understand that hospice visits tend to be concentrated in the beginning as well as at the end of a hospice election. This concentration of care was factored into the initial computation of hospice payment rates. We concur with the GAO that the mean daily costs may be different today because of changes in length of stay (pp 21). However, we are not sure that this translates into insufficient payment to hospices. Payment rates have increased each year by the market basket value. The wage index has reflected the annual changes in wages by geographic location. While in the past, hospice staff provided a large portion of care, today families and friends are increasingly providing a larger portion of care, including skilled nursing care traditionally provided by hospice nurses. It would be useful to see if the number of visits and time spent by hospice staff has changed over the years.

In terms of small providers, the draft report states, "...small freestanding hospices had higher average per diem costs than other hospices, which could signal problems with the distribution of payments. As a result, modifications to the hospice payment methodology may be warranted." The CMS does adjust the wage index by applying a hospice specific wage index floor. Areas with a hospice wage index below 0.8 are adjusted by the greater of: (1) the hospice budget neutrality factor; or (2) the hospice wage index floor (a 15 percent increase) subject to a maximum wage index value of 0.8. However, before other payment methodology modifications are made, we believe additional information would need to be obtained to ensure that inefficient practices are not rewarded by additional payment. The CMS is not aware that small freestanding hospices are experiencing deleterious effects due to Medicare payment.

GAO Recommendation

CMS should implement those modifications that would not require a change in Medicare law and submit a legislative proposal to the Congress for those that do.

CMS Response

Should it be determined that legislative changes are required, CMS will evaluate those changes as part of its overall legislative strategy.

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