

Opening Statement of Sen. Chuck Grassley
Monday, Sept. 18, 2000

Thank you all for attending today's hearing. Senator Breaux has been unavoidably held up, but will be joining us as soon as he can.

Today's hearing continues the Committee's focus on end-of-life care. In July, we held a hearing which highlighted the need for more education in this area.

Well, it seems that that educational process is picking up speed. I'm sure many of you watched the PBS series last week, and end-of-life care is also on the cover of Time magazine right now. I hope we can keep up this great momentum.

While that educational effort continues, today we turn our attention to the role of the government in end-of-life care. One of the most farsighted things Congress has ever done for our Medicare beneficiaries was to add a hospice benefit. It's an honor to have my friend, Senator Bob Dole, here today, because he was instrumental in getting it done. Over the years, it's also been my honor to visit many hospice providers in my home state of Iowa. Hospice sets a standard for caring, coordinated, comprehensive services that I'd like to see the rest of Medicare meet.

But it has become clear to me that many Medicare beneficiaries are not getting the full benefit of hospice care. The GAO report that will be presented today identifies the problem: while more and more Medicare beneficiaries are receiving hospice care, they are receiving it for shorter and shorter periods of time. The number who receive less than a week of hospice rose sharply during the 1990s.

Why is this a problem? It's a problem for hospices, because patients in their final week of life have very high costs, and if they can't balance those patients against less expensive patients, they can't break even. Even worse, short lengths of stay hurt patients and their families, because they struggle for too long without the support hospice offers. This is what I'm referring to when I use the term "shortchanged."

Having identified short stays as a key problem, next we want to understand the reasons for this trend, and what can be done to reverse it. As you will hear today, there are many barriers. But let me focus on a few that are sure to come up today. One is financing.

As Dr. Christakis notes, studies have found that hospice saves substantial amounts of money compared to traditional coverage. But many hospice providers assert that Medicare's hospice payment rates are inadequate, especially given the dramatic increases in drug costs in recent years. This year, the Medicare payment for a routine day of hospice care in the home is just under \$100. In the year 2000, that doesn't seem like a lot of money to take care of someone who's dying. Unfortunately, hospices have only recently begun to report their costs to the government, so GAO will not be able to examine this issue until next year. But I do want to hear from our provider witnesses on their experiences.

A second issue: Medicare's requirement that a physician must certify that a patient is likely to die within six months. One question is whether this rule makes sense, given the difficulty of predicting the course of illness. A second question is whether the government been reasonable in interpreting and enforcing this rule? We've long heard complaints about confusion as to whether six months is a hard and fast limit - it isn't - and about heavy-handed enforcement of the rule. If these things are going on, that would help to explain why patients are admitted to hospice so late.

We've been hearing these concerns for years. But apparently HCFA has now concluded that there is a

problem. On Thursday HCFA mailed out a clarification of the rule. This clarification probably would have been useful much sooner, but I welcome it now, and I hope it signals a renewed focus on improving Medicare hospice.

By the way, there are now several years of history of this Committee spurring the executive branch into action. Let me list a few instances:

- In May 1999, at our hearing on the home health OASIS assessment, HCFA announced that the OASIS requirement would be limited to Medicare and Medicaid patients.
- The President announced a 21-point Nursing Home Initiative (NHI) exactly one week before the first Aging Committee oversight hearing on nursing homes in July of 1998.
- HCFA modified its policies for nursing home complaints and enforcement in preparation for an Aging Committee hearing centered around a GAO report in these two areas in March 1999.
- In July of this year, HCFA released its report on nursing home staffing just two days before an Aging Committee hearing on the topic of nursing home staffing shortages. Just this weekend, knowing that I was working on an initiative on nursing home staffing to be included in the upcoming Balanced Budget Act revisions, the President announced a legislative proposal in this area. At the July hearing, Adm. De Parle said that they would have to wait until completion of phase two of the study --approximately a year -- before they could take action. So, the President's announcement comes as a welcome surprise.

I could cite other instances, and now I welcome HCFA's letter on hospice. In my view, this tells me that Senator Breaux and I are doing something right, because I think getting the government focused on better serving the American people is one of the most important things Congress can do.

There are many issues to cover today, so I'll stop there and yield to any of my colleagues who wish to offer opening statements.

Closing Statement of Sen. Chuck Grassley

I want to thank all the witnesses for their testimony. It's amazing that this small piece of Medicare involves so many complex and important issues. But if we're serious about helping people have a better ending to their life, we need to deal with these issues.

Firstly, based on what I've heard today, I do not think hospice providers can wait until next year for relief on their Medicare payments. While in a perfect world we'd have better data on costs, we have to make decisions based on the information we have, and I think an increase in the base hospice rate should be part of this year's Medicare package. I plan to communicate this to Chairman Roth right away.

Secondly, it is very significant that HCFA has finally acknowledged the need to improve hospice in Medicare. Realistically, I don't anticipate Congress addressing any hospice issues other than financing in the short time available this year, but I would like to see it be part of the broader effort to strengthen Medicare that I anticipate next year. So I plan to write to HCFA urging that it review the hospice benefit and make concrete, serious legislative recommendations to Congress early enough in the new year to be useful in the Medicare discussion. I have an open mind on the timing, but a reasonable timeframe might be for HCFA report to us by six months from today, March 18, 2001. This will give HCFA staff time to develop proposals and the incoming Administration time to make final decisions. I would urge HCFA to listen to input from hospice providers, patients and caregivers, and policy experts, and I am certainly willing to have my staff involved as well. If any of my colleagues would like to join me in making this

request, I'd welcome that.

As to what should be considered, HCFA has already indicated that it will consider a program for provider guidance on eligibility issues. I would like it to expand that process to include other key issues we addressed today, such as the following: in light of prognosis issues, should a new eligibility criterion replace the six-month rule? If we retain the six-month rule, is statutory language needed to clarify it once and for all?

Does Medicare need to undertake a professional and public education campaign on the hospice benefit? Should Medicare payments be adjusted to reflect special challenges posed by individual patients, for example, those who have no family caregiver, or those who live in rural or inner-city areas? Is current Medicare reimbursement adequate? Is the requirement that a patient electing hospice surrender all rights to curative care still appropriate? Should providers serving rural areas be relieved of some regulatory burdens because of their special constraints?

These are some of the questions I will urge HCFA to consider. But I hope that they will agree that this review is needed, and that when they do it, they will make use of the record of today's hearing, because I think it was most helpful. I thank all the witnesses; this hearing is adjourned.