A Short History of the Medicare Hospice Cap on Total Expenditures

**Question?**

An increasing number of hospices are incurring costs that place their annual payments above the Medicare hospice cap. When this occurs, Medicare retrospectively recovers the difference between the cap amount and its payments. The cap is computed to reflect the number of “unduplicated” Medicare beneficiaries served during the year but it is not adjusted for regional differences in wages and operating costs. Questions have arisen as to the origin and structure of the cap and whether geographic adjustments were considered when it was developed.

**Answer.**

Medicare’s hospice cap, as originally enacted, did include a detailed methodology for computing and updating the cap using program data and a process for making geographical adjustments for the regional cost of services; however, the law was amended before implementation to eliminate all this material and, instead, specify a specific cap amount and an updating methodology.

**Background**

Medicare’s hospice benefit was enacted in 1982, at a time when concern over the nation’s budget deficit had led the Congress to begin using a budget-setting mechanism that required coordination of the established budget with a “reconciliation” that adjusted program costs so that expenditures would meet the budget targets (which would then be reflected in the appropriations). Under the new process, the cost of new laws was estimated and new provisions were required to be funded by explicit recognition in the budget or by reductions in other expenditures in the base line (i.e., in the existing program). Provisions of law most likely to be enacted, therefore, were provisions that either produced savings that could be used to fund other changes or provisions for which there was no additional cost.

The legislative efforts of hospice advocates were also being made at a time when actual data on Medicare hospice costs and expenditures was not available. Medicare’s hospice demonstration project had been undertaken but had neither been completed nor evaluated. On the other hand, there was information available upon which estimates could be based. For example, Medicare researcher Jim Lubitz was in the midst of conducting a study of Medicare expenditures for patients both annually and specifically in the last year of life, research that he subsequently updated in *The New England Journal of Medicine* (328: 1092-1096 [April 15] 1993). As a point of reference, his research indicated that in 1988 the average Medicare beneficiary’s care cost in the last year of life $13,316, of which 52%, or $6924 was spent in the last 40 days of life. All of the Lubitz studies have indicated that the 52% proportion holds pretty much true. At the time legislative efforts were under way, the average hospice length of stay was about 40 days.
(Statement of Senator Heinz in the Congressional Record of July 22, 1982 (page S8965). The researchers conducting and evaluating of the Medicare Hospice Demonstration had also done much yet to be published work on costs. The researchers concluded that savings could not be absolutely guaranteed because they depended upon the case mix of the population served under the provision but that it was highly likely that there would be savings and very unlikely that hospice care could cost more than the costs Medicare would bear absent hospice. (The Hospice Experiment, edited by Vincent Mor, Ph.D., David S. Greer, M.D., and Robert Kastenbaum, Ph.D., Johns Hopkins University Press, 1988.) Information from all these sources was available to hospice advocates and their congressional supporters.

Hospice advocates and their supporters felt confident they could get support for enactment so long as their program was “budget neutral,” and that its chances would be enhanced if savings could be projected. Savings were predicted and budget neutrality was assured by a “fail-safe” cap on hospice payments that was set at 40% of the average Medicare expenditure for cancer patients in the last six months of life. Committee staff drafting the legislation had various estimates that led them to believe the initial cap would be about $6500, an amount hospice advocates all agreed was well above the average cost of caring for a hospice patient. In order to place the cap in the context of program expenditures, instead of simply enacting a specific amount, it wrote the statutory language as a set of instructions to the Secretary of HEW for the computation of the cap. The instructions specified the sources of data for the calculation and also required the Secretary to adjust the cap for regional differences in the cost of treatment.

Confusion by staff drafting the cap provision led them to specify data sources and a process for computing the amount that led Medicare’s actuaries to establish a much lower figure than they had intended: $4232. When the actual cap amount became known by the hospice advocates (well before it appeared in the Federal Register of August 22, 1983), there was a considerable controversy and spirited debates over whether the Secretary had acted in good faith before it was recognized that there would need to be a change in the law. The change was quickly enacted in Public Law 98-90 on August 29, 1983. The new law deleted the complicated formulation for development and adjustment of the cap amount and, instead, specified that the cap would be $6500 in the first year, adjusted by the medical care expenditure category of the consumer price index for all urban consumers published regularly by the Bureau of Labor Statistics. The Report of the Committee on Ways and Means (Report No. 98-333) explained the error made in the original legislation and promised that there would be no impact on the Medicare Trust Fund as a result of the change.

The final hospice regulations published on December 16, 1983, contained the new $6500 cap amount and a discussion of the updating process.

Summary

The original legislation contained a cap amount intended to be a “fail-safe” guarantee of budget neutrality. As written, the cap would have been adjusted to reflect regional
differences in the cost of care. As revised, it applied the same cap amount to all regions.

The language of the original statutory cap provision and the subsequent amendment to it are shown below.

**Original Hospice Cap Provisions (P.L. 97-248)**

**Payment for Hospice Care**

1814(i) (2) (B): For purposes of subparagraph (A), the “cap amount” for a region for a year is computed as follows:

(i) The Secretary, using records of the program under this title, shall identify individuals (or a representative sample of such individuals) –

(I) who died during the base period (as defined in clause (v)),

(II) with respect to whom the primary cause of death was cancer, and

(III) who, during the six month period preceding death were provided with benefits under this title.

(ii) The Secretary shall determine a national average medicare per capita expenditure amount by (I) determining (or estimating) the amount of payments made under this title with respect to services provided to individuals identified in clause (i) during the six months before death, and (II) dividing such amount of payments by the number of such individuals.

(iii) The Secretary, using the best available data, shall then compute a regional average medicare per capita expenditure amount for each region, by adjusting the national average medicare per capita expenditure amount (computed under clause (ii)) to reflect the relative difference between that region’s average cost of delivering health care and the national average cost of delivering health care.

(iv) The “cap amount” for a region for an accounting year is 40 percent of the regional average determined under clause (iii) for that region, increased or decreased by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the consumer price index for all urban consumers (U.S. city average), published by the Bureau of Labor Statistics, from the fourth month to the fifth month of the accounting year.

(v) For purposes of this subparagraph, the term “base period” means the most recent period of 12 months (ending before the date proposed regulations are first issued to carry out this paragraph) for which the Secretary determines he has sufficient data to make the determinations required under clauses (i) through (iii).
Revised Hospice Cap Provisions (P.L. 98-90)

(B) For purposes of subparagraph (A), the “cap amount” for a year is $6,500, increased or decreased, for accounting years that end after October 1, 1984, by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the consumer price index for all urban consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year.