UpDate

UpDate is a section that will report developments in health policy issues and scheduled conferences of relevance to the field. This issue features a summary of a conference on health cost management held at Boston University's Health Policy Institute and an analysis of the Medicare Hospice Benefit.

Health Cost Management at the Community Level: Doctors, Hospitals and Industry

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Ever since the federal government became centrally involved in the provision of medical care in the United States, many interests with a heavy stake in the nation's health care enterprise have looked to Washington for solutions to the system's problems. The litany of these problems and their proposed solutions is familiar to practicing physicians, hospital administrators, large corporations that insure their work forces, and labor unions that strive to protect the interests of their members.

To extend access to individuals without medical care and, somewhat contradictorily, to constrain costs, the proposed solution throughout the 1970s was national health insurance. To chart the development of health care facilities and regulate their size, Congress enacted a national health planning law. And to monitor the quality of federally financed care, Congress created a national network of peer review organizations, sanctioned and largely administered based on standards set in Washington.

In fashioning these proposals, Congress, in effect, imprinted its judgments in a centralized manner on a medical care system that is essentially comprised of thousands of locally based health subsystems that reflect the great diversity of the United States and all of its attendant complexities. Though this preoccupation with national solutions served to focus attention on the problems faced by the medical care sphere, many of the problems remain, particularly the rising cost of care.

Obviously, Washington's involvement in health care is not about to end, but its focus has narrowed to include mostly publicly financed programs like Medicare and Medicaid. At the same time, the United States generally has become more suspect of government solutions that dictate national policies from Washington without due regard to regional diversity.

This shift from a total emphasis on Washington to a new diversity that involves the federal government, as well as growing activity on the local level, is pronounced in the health sphere.

The signs of this locally based activity abound. Some 100 private-sector coalitions of businessmen, labor leaders, hospital administrators, doctors, and other interested parties have been created to address health delivery issues. The American Medical Association considered this trend important enough that it created an office to assist private coalitions and encourage physician involvement. The AMA also published a handbook entitled, "The Formation of Medicine/Business Coalitions."

The Chamber of Commerce of the United States also is promoting the concept of local health care coalitions, as is the Washington Business Group on Health, an organization of 200 large corporations of the *Fortune* 500 variety. The Robert Wood Johnson Foundation created a new program last year that will invest some $16 million in community-based projects that seek to implement innovations intended to moderate the cost of medical care. The Pew Memorial Trust of Philadelphia and the John A. Hartford Foundation of New York City also are investing significant amounts of their philanthropic funds in locally sponsored projects that seek to improve the existing delivery system through private means rather than government action.

Recognizing this flurry of activity and the relative absence of information on its impact in given locales, Boston University's Health Policy Institute sponsored a conference on "Health Cost Management at the Community Level: Doctors, Hospitals and Industry." In a one-and-a-half day session thirty-five participants representing these interests discussed mutual problems and possible solutions. The focus of the discussions was on five state and local projects that are striving to improve the health care system through the cooperation of private and public interests.

The projects that were discussed in detail at the Boston University conference are underway in Rochester, New York; the state of New Jersey; Blount County, Tennessee; Wilmington, Delaware; and Birmingham, Alabama. A key difference between these programs is the degree to which they have been formulated voluntarily by private interests or mandated through government action. In the discussion that ensued on these projects, conference participants were struck by the diversity of the environments in which they operate and recognized that what works in Rochester or New Jersey may well have little prospect of achieving success in other locales.

Rochester, New York

Perhaps more than any other city in the country, Rochester's health community—private corporate purchasers, physicians, hospitals, and medi-

cal educators—worked cooperatively early on to shape their local health care delivery system. This partnership was formed largely through the initiative of Marion B. Folsom, a long-time executive of Eastman Kodak, which is headquartered in Rochester, and a former secretary of the Department of Health, Education and Welfare (1955-1958). Long before the federal government imposed a health planning structure on communities, Rochester created its own voluntary planning program that sought to match local health care needs with available resources.

Influenced by this tradition, nine area hospitals formed the Rochester Area Hospitals' Corporation (RAHC) four-and-one-half years ago to serve as the administrative umbrella over an effort to restrain the growth of health care costs on a voluntary basis. The founding hospitals support RAHC through payment of dues allocated in proportion to each hospital's budget. The nine participating hospitals range from two hospitals of under 100 beds in semi-rural communities to a tertiary care hospital of more than 700 beds at the University of Rochester Medical Center.

Before the hospitals got involved in the experiment, which is recognized and, in part, funded by the Health Care Financing Administration, their reimbursement for services was based on government regulations that were often contradictory, that did not permit hospitals to accurately predict their income, and that invariably resulted in hospitals losing revenue when cost reductions were achieved. By 1978, the solvency of hospitals in Rochester—and elsewhere in New York—was seriously threatened.

To counter this problem, Rochester's health care leaders joined together to develop an alternative to the state's arbitrary regulatory model that would demonstrate their commitment to a local system of self-control. The control mechanism is a total revenue cap, calculated by projecting each hospital's base year costs to the rate year using inflation or "trend" factors to account for price increases in the goods and services that hospitals use and a 1 percent annual provision for working capital. Additionally, 2 percent is added each year to the trend factors to allow payment for increased volume of hospital services, incremental operating expenses associated with certificate-of-need projects, and unforeseen events.

Dr. Frank E. Young, dean of the University of Rochester School of Medicine and Dentistry, said the RAHC sought to incorporate in the payment mechanism incentives that would reward hospitals "for beating the system in the way we would like it to be beaten," would emphasize prudent management, and would allow institutions to retain savings. "It's surprising how many changes can be made if a hospital can keep the bottom line," Young said. "We saw very rapidly a consolidation of two neonatal intensive care units into one. The one hospital couldn't get rid of it fast enough."

Emphasizing the importance of the partnership in Rochester, Young said: "I fully contend that an interactive, supportive, working relation-

ship between industry, the health centers, the community hospitals, and physicians and nurses is essential for the development of these kinds of systems."

Living under a self-imposed annual budget ceiling incorporates "new incentives" into the hospital environment, said Leo P. Brideau, deputy director of patient care services at Rochester's Strong Memorial Hospital. "It's a different world; keeping the beds filled, keeping the census up, is something that has become foreign to Rochester's hospitals. Keeping the census down is what we work at very hard because it's to our benefit to do so," though Brideau conceded that at this point Strong Memorial has not succeeded in reducing its patient load.

Brideau said the first thing that strikes a hospital administrator who strives to reorient his institution along these new lines is that the "financial incentives, from the hospital's point of view, are directly in opposition to the financial incentives of the physician. His incentives are to keep the patient, to do more for the patient, to admit; our incentives are precisely the opposite and that's a potential source of conflict and one that we need to address by trying to turn the physician incentives around to parallel ours."

New Jersey

New Jersey's approach to prospective payment for hospitals is very different than the locally based, voluntary system designed by the leader of Rochester's private health sector. New Jersey's 116 hospitals operate under a state-regulated payment scheme that was enacted in 1978 by the legislature. Three important changes in New Jersey laws governing hospital reimbursement were incorporated in the 1978 statute. The law extended the state's authority to control hospital reimbursement from Medicaid and Blue Cross to all payers. Second, the new law required that the costs of uncompensated care be spread across all payers, including Blue Cross and Medicare. And finally, the 1978 statute created a five-member Hospital Rate Setting Commission to approve or adjust all hospital rates.

Bruce C. Vladeck, an assistant vice-president of The Robert Wood Johnson Foundation, was largely responsible for implementing New Jersey's prospective payment plan while serving as an assistant commissioner of the Department of Health. Vladeck, a political scientist, told the conference the law was enacted "to meet a number of very ambitious and, to a considerable extent, widely perceived as conflicting objectives. It was a system of cost containment; at the same time, it was a system that was designed very substantially to reallocate costs among various payers . . . to, in essence, reallocate costs from hospitals that had a lot of affluent customers to inner city hospitals that served the uninsured poor."

New Jersey's hospital payment mechanism is of particular significance because the state bases its rates on payment per case as measured by diagnosis-related groups (DRGs), a controversial patient classification system developed by researchers at Yale University. Congress, in the Tax Equity and Fiscal Responsibility Act of 1982, directed the Department of Health and Human Services to develop a Medicare payment scheme along the lines of the DRG-based system, thus making New Jersey something of a national laboratory for prospective payment.

New Jersey's approach to hospital payment is more complex than that of Rochester's but both systems reverse many of the traditional economic incentives that have driven institutionally based providers. Also, both approaches demand that hospital administrators and attending physicians work more closely together because the institutions operate at some financial risk based on how doctors provide care to inpatients.

Representatives of two institutions, Morristown (New Jersey) Memorial Hospital and Overlook Hospital of Summit, New Jersey, discussed how they have sought to improve the cost-efficiency and quality of care rendered through aggressively implementing the DRG-based payment method. Vladeck, pegging the performances of Morristown and Overlook among all New Jersey hospitals, said they were "among the best . . . in the state. They're not the only good ones, but out of 100-some hospitals, there are fifty that still haven't had the administrator and the medical staff discuss together implementation of DRGs."

Dr. Warren Nestler, a cardiologist who has practiced at Overlook for more than two decades, currently is that hospital's vice-president for quality assurance. Nestler explained how Overlook has incorporated the clinical and financial data generated by the DRG system into its quality assurance program and has employed its existing medical staff structure as the primary means to communicate with physicians. "To survive under this hospital reimbursement approach requires that a hospital maximize its revenue and minimize its costs. Like your (Rochester's) system, you save it, you keep it."

Overlook reorganized its administrative structure, creating a DRG Committee headed by its chief executive officer, hired a DRG coordinator, significantly upgraded its capacity to maintain accurate medical records and sought—from the beginning—to centrally involve physicians. "It became evident that the physicians controlled the dollars and, if cost containment was going to occur, it required physician participation."

Nestler described the critical steps necessary for Overlook to maximize its revenue under a payment system based on a patient's diagnosis: "First, we have to assure a valid DRG classification for every diagnosis. A hospital's whole revenue depends upon the validity of what goes down to the state on that discharge abstract. The second thing we sought was the minimization of costs. We're down to discussing the elimination of unnecessary

admissions, unnecessary hospital days, overtesting, and overtreatment. We are striving to minimize complications of medical intervention . . . an extremely expensive part of the health care system. We also are striving to maximize the efficiency of services that are produced and discontinue unnecessary services."

Don Bradley, president of Morristown Memorial Hospital, described a similar approach to the implementation of New Jersey's new payment scheme, but emphasized that it is more than just a payment system. "It is a medical management system, too. . . . At long last now, I have got something to talk to a physician about in terms of his rate of consumption for a similar procedure compared to one of the members of his peer group."

Dr. Robert Ambrose, Morristown's medical director, elaborated on how physicians have responded to the new per-case hospital reimbursement plan. Morristown, too, created a DRG Committee, but it was organized as a medical staff committee, with a physician as chairman. At first, Ambrose reported, the DRG Committee was "at sea. . . . So we asked the hospital's data people for DRGs which were running large negative variances. A negative variance is a euphemism for red ink. They picked out large losses in different specialties: eye, surgery, medicine, among others. Then we would invite in the chairman of that department and ask, in a very nonthreatening way, 'Do you have any idea why your department lost money in that cost center?'"

Ambrose continued: "The department chairmen would take that data back to his department and talk it over with his colleagues. We would then reaudit that DRG in six months. Lo and behold, in every instance the average length-of-stay had decreased and the dollar volume went from a negative figure or loss to either a smaller loss or a gain."

Dr. James S. Todd, a surgeon in Ridgewood, New Jersey, and a member of the AMA's Board of Trustees, offered two other incentives that encouraged physicians, where appropriate, to alter their practice patterns under the New Jersey system: professional integrity and maintaining the financial solvency of the hospital in which each doctor practices. "These are two reasons why physicians change their behavior without any firm stick being held" over their professional heads, Todd told conference participants.

J. Joel May, a respected health services researcher, is president of the Health Research and Educational Trust (HRET), an independent, Princeton-based health policy research organization in New Jersey that has been engaged in evaluating the state's DRG-based payment system for the past three years. At the Boston conference, May addressed the issue of whether this payment approach had demonstrated any cost savings. May told the business interests: "The system, as designed by the Department of Health, has the potential for reducing the rate of cost increase in hospitals.

Specifically, it is capable of providing incentives to decrease the cost per admission of hospital care by rewarding the hospital for doing so. Whether it will or not depends upon how the Department of Health manages it. To date, it is my judgment that it has not. In the first year of the system, under the terms of Chapter 83 of the New Jersey code, the law which implemented the system, hospitals received more money than they otherwise would have and, hence, had little incentive to reduce costs."

Vladeck conceded that at this point DRG-based payment has not resulted in cost savings. He told the conferees: "The state law and the agreement with the federal government upon which it granted a Medicare waiver assumed a substantial degree of generosity in the initial payment rates and a gradual tightening of the payment system over time. Numbers on the anticipated savings must be seen from the viewpoint of a system that was deliberately generous within the constraints of the technology of the system. Our working motto was that nothing so much eases the friction of something new as a lot of financial lubrication, so that was a conscious kind of activity."

In both New Jersey and Rochester, the critical importance of developing data systems that generate accurate information was emphasized by conference participants. In New Jersey, where state government dictates payment levels based on diagnosis data, the very survival of a hospital could depend upon the accuracy of the medical record. In comparing the two systems, Young, the university medical dean from Rochester, said: "Our incentive is much more indirect in that we are not going to affect any real changes in practice patterns until we have got good data, whereas in New Jersey it is much more direct and so there is a greater incentive" to maintain accurate medical records.

Other Communities

Boston University also invited to its conference representatives of communities where there are no financial incentives in place to stimulate change, but there is a mounting concern over the rate at which medical care costs are rising. What these other communities—Blount County, Tennessee, Wilmington, Delaware, and Birmingham, Alabama—did have in common was the presence of a major employer which had expressed concern over the rate of growth in health costs.

In the case of Blount County, the employer is Aluminum Company of America (ALCOA); in Wilmington the involved employer is E.I. DuPont de Nemours Company. In Birmingham, South Central Bell Telephone Company has begun to play a role in examining the health care delivery system there. All three employers are major purchasers of care in their respective areas. The efforts underway in all three communities point up the difficulty of changing the existing health care system without the

pressure of a specific government mandate or the resolve of a highly motivated corporate-medical coalition.

James R. Robinson, former employee benefits manager at DuPont, said the company's concern became pronounced when in 1977 "we went to our executive committee—the five people who really run the firm—and said, 'By 1980, our cost of providing medical care to our employees is going to be $100 million and that is $1 a share.' Now, a dollar a share grabs the attention of people like our executive committee. Out of this meeting came a real interest at the executive committee level, saying, 'We better do something about this.'"

DuPont studied various approaches to attack the problem of rising costs, including the sponsorship of a health maintenance organization, a step the company decided not to take. The local medical society was described by Dr. Anthony Cucuzzella of the Wilmington Medical Center as being "terribly antagonistic toward the idea of an IPA (individual practice association)." To date, DuPont has taken no major steps to address the problem it became concerned about five years ago. As one Wilmington participant at the Boston meeting described it: "I would have to say that in Rochester, New Jersey and (Blount County) Tennessee they have come to the wharf, taken their clothes off, and are halfway across. In Wilmington, we have not one shoe and one sock off. We have got no data to go on. I agree with Tony (Cucuzzella), it's slow. We will have something to report perhaps in a year."

In Blount County and Wilmington, ALCOA and DuPont sought to create climates that were nonadversarial. Both corporations invited physicians and hospital administrators in their respective communities to discuss with them rising health costs and what steps might be taken to address the problem. Harry S. Glass, director of programs in health utilization management at Boston University's Center for Industry and Health Care, told the conference that the center offered ALCOA and DuPont "technical assistance" to address the issues which face any community that strives to change its health care delivery system.

Using data supplied by local hospitals, Glass and his colleagues sought to identify practice patterns that "might be amenable to greater efficiency through our access to the literature and knowing who is doing what around the country." The central purpose of the dialogue was to make physicians aware of utilization data so they could compare their practice patterns with those of other doctors.

Glass emphasized: "These programs lacked some of the financial teeth of the previous two (Rochester and New Jersey). In New Jersey there are clear incentives. And the same thing is true of Rochester." The exercises in Blount County and Wilmington are tests to determine the commitment of employers and providers alike to solve their common problems within the framework of the private sector through peer pressure, the

dissemination of data, and making available the latest medical practice information, Glass said.

Dr. Colin L. Kamperman, medical director of ALCOA's Tennessee operations, has been an active participant in the Blount County meetings, as has Dr. Henry S. Nelson, a private practitioner in Maryville, Tennessee. Nelson said the primary activity has been the evaluation of specific variances in the practice patterns of individual physicians. "So far, the question of whether the change in practice habits is going to be beneficial has not been answered," Nelson said. But the dissemination of the data has demonstrated that "there is a fair amount of variance within the medical community in this one location."

Floyd M. Smith, a representative of South Central Bell Telephone Company of Birmingham, Alabama, described the concern of the corporate community there that led fifteen companies in 1978 to meet to discuss the problem. One of its earliest steps, Smith said, was to gather medical care use data for the eleven largest industry groups in Birmingham. These eleven groups consume 70 to 80 percent of the medical care provided there. Smith said: "We keyed in on physician practice habits because they controlled the admissions; we reasoned, if we could persuade physicians to change their practice habits, then perhaps we would could further reduce the cost."

Smith said the companies worked through the AMA to attract the interest of local physicians. Another step taken by the coalition of business representatives and physicians in Birmingham was the development of a position paper in September, 1980 that encouraged physicians—on a voluntary basis—to consider changes in their practice patterns. Hospitals compete so intensely in Birmingham that is has been impossible to enlist their cooperation in a health care coalition.

Most recently, Dr. Peter W. Morris, who attended the Boston meeting as a representative of the Jefferson County (Ala.) Medical Society, has been developing a payment approach that would encourage physicians to perform workups of selected diagnoses on an outpatient basis rather than hospitalize the patient. Morris said that through the experimental payment approach, internists receive a global fee for an outpatient diagnostic workup, but are also allowed to bill for any laboratory procedures, consultations or x-rays. In this way, internists are paid an equitable fee and do not have to hospitalize a patient for a diagnostic workup simply because insurance companies will not reimburse such work on an outpatient basis. More than 200 of Birmingham's estimated 350 internists have agreed to participate in this experiment, "to be a part of the movement," as Morris characterized it. Insurance companies are cooperating as well in the demonstration.

Morris conceded that physicians in Birmingham have little economic incentive to participate in the experiment, but he said they do have a

keen interest in limiting the involvement of government in medicine. "When we first got involved (with the demonstration), we said our intent was to preserve our present health care system."

Issues For The Future

If physician leaders agree that many diagnostic and treatment procedures are not necessary for the optimal treatment of their patients, the challenge is to develop appropriate incentives for physicians to change their practices in the direction of greater efficiency. Experience with most peer review programs, which have been based on simple feedback of information on length-of-stay or use of tests, has not demonstrated that major improvements in practice efficiency will result from informational peer review alone. The efforts underway in Blount County, Tennessee, and Wilmington, Delaware, suggest a role large corporations can play to encourage local physicians and hospitals to develop utilization management programs.

There are two kinds of economic incentives for physicians to practice more efficiently. The first is indirect and already exists in states like New Jersey where hospitals are paid on a case-mix basis, and in Rochester, New York, where the nine local hospitals are paid a global budget. Although there is little evidence to date that local physicians have markedly altered the ways they practice, the fact that the hospital in which they work can keep savings from efficiency provides the basis for ongoing dialogue between hospital management and the medical staff. As the hospital financial situation becomes tighter, clinical departmental budgets will increasingly be dependent upon a more parsimonious use of hospitalization or procedures. Physicians may not have access to new diagnostic devices or radiological procedures for the care of their patients without economies in clinical practice, and that fact will involve clinical departments in resource use-control programs that will become as much a part of clinical administration as the professional meetings on quality of care that are an integral part of all good clinical services.

Direct financial incentives will be seriously considered only if indirect economic incentives are ineffective. The suggestion has been made, for example, that surgeons who are paid a global fee for the entire operative experience could be paid a larger amount if they hospitalize their patients for a shorter time than is usual for the community. North Carolina Blue Shield has recently started a program of paying surgeons larger fees for doing surgical procedures in ambulatory facilities than in the hospital because of the lower unit costs associated with nonhospital settings. Of course, there would have to be professional agreement on the appropriate range of treatments and careful monitoring of practice so that undertreatment does not occur.

The complexity of the nation's health system is such that, even if a widespread decrease in average length-of-stay were to be achieved, there is no guarantee of savings without some shrinkage of the hospital system. Otherwise, hospitals would spread their overheads over a smaller number of patients, and hospital occupancy rate would fall. And, if patients who would not have been hospitalized fill the empty beds freed up as a result of greater physician efficiency, overall health costs may increase because of the greater intensity of care which the hospitals would experience. For these reasons, any cost management program based on utilization controls must also include a component directed at hospital capacity. Because of the greater hospital needs of our aging populations, it is possible that hospital expansion can be avoided, rather than having an actual decrease in capacity with its attendant loss of jobs and decrease in operating budgets.

The combination of federal and state budgetary pressures on health entitlement programs, and industry's concerns about the inflation of health benefits, combine to create an imperative for the development of effective cost management programs. Practicing physicians must be at the heart of these activities because of concern for their patients, and the need to monitor quality of care as resource use is reappraised.

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The Medicare Hospice Benefit: Unanticipated Cost And Access Impacts?

As a result of passage of P.L. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), a hospice benefit under Medicare for the terminally ill will become available for a period of three years, beginning November 1, 1983. Although the hospice provision appeared to have everything going for it in an election year, the provision was not included in the bill until Congress was reasonably convinced, primarily by a Congressional Budget Office (CBO) study completed in June, 1982, that the benefit would save, or at least not increase, Medicare costs. The CBO analysis estimated that once beyond the first two-year start-up period, the more Medicare beneficiaries who utilized the benefit, the greater the savings to the Medicare program because less expensive noninstitutional services would replace very costly inpatient care. That some doubt concerning cost implications still lingered in the minds of Congress, however, is evidenced by the sunset clause withdrawing the benefit in October, 1986, and by the call in the legislation for an ongoing evaluation of program costs throughout the next three years. Congress also requested a report on the National Hospice Demonstration project by September 30, 1983.

The caution giving rise to these provisions of the bill appears well-founded. The real Achilles' heel of the cost projections used to justify passage of the bill could turn out to be an unanticipated rise in demand for the benefit stemming from the designation of a six-month life prognosis as the key eligibility criterion for receiving hospice services.

Potential Demand From Noncancer Patients

One source of increased demand resulting from the passage of TEFRA is obvious and clearly is anticipated. This is the improved access to hospice services experienced by persons with terminal cancer who hitherto would have used hospice services (but did not) had they possessed third-party coverage for such services, or if hospice services had been available in their locality. Enhanced access, of course, is the principal purpose of the legislation.

Increased access to hospice services as well as the enhanced knowledge, visibility, and acceptability of hospice care that will grow from its inclusion under Medicare also suggest that substantial demand could arise from "terminally ill" persons with diagnoses other than cancer—some portion of whom might not have used acute care services to the extent

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that terminal cancer patients do. As Mor and Birnbaum point out, up to 20 percent of the patient population of some of the hospices included in the National Hospice Study (in which the current restrictions on the use of hospice services under Medicare are waived) have diagnoses other than cancer.[1] Framers of the legislation appear to have assumed that only 5 percent of the hospice population would have noncancer diagnoses and that, therefore, the upper boundary of utilization would be constrained by the size of the population having terminal cancer.[2]

Average Length-Of-Stay

Noncancer Patients. Should substantial demand arise from the population terminally ill with conditions other than cancer, the average length-of-stay for hospice patients could rise significantly. Such an increase would constitute a highly important development, as CBO estimates of costs (and cost-savings) of the Medicare benefit assume a continuation of a forty-five-day average length-of-stay reflective of hospice experience to date. The 40 percent cap (pegged to average costs of conventional care for the last six months of life) imposed on expenditures under the benefit is based, in part, on this assumption.

A principal reason that average length-of-stay could rise is that point of death for persons with other terminal illnesses (which can be a very broad category, including heart disease, end-stage pulmonary disease, and even senile dementia) appears to be extremely difficult to predict. Given such unpredictability, it is entirely possible, of course, that average length-of-stay would change little, if any, because overestimation of days of life would balance out underestimations. However, as will be pointed out momentarily, this "wash" does not occur even with terminal cancer patients.

Overall, the errors of underestimation seem likely to outweigh the errors of overestimation.[3] Although they provide no specific documentation, Mor and Birnbaum assert that "noncancer patients have significantly longer stays in the hospice. Predicting length of life for noncancer patients is much more tenuous, that is, there is much greater variability in the length of life."[4] Prediction is particularly complicated for the elderly, the largest segment of both the terminally ill population and the chronically ill population, because of the greater likelihood of their having multiple diagnoses.

The physician, of course, is assigned no liability for an inaccurate prognosis. Moreover, since hospices are prohibited from discontinuing services to patients who live beyond their eligibility period, no risk of loss of hospice services exists for the patient or family either. Furthermore, it appears that the patient's eligibility for the traditional acute care benefit can always be reinstated (if the patient or legal guardian so elects by renouncing further hospice care for that benefit period) at any point be-

fore the full 210 days of eligibility for the hospice benefit are used up. In the final analysis, it appears that the only parties at risk are the hospice and the Medicare program, which would be reimbursing the costs for the provision of home-based services not presently covered by Medicare.

Cancer Patients. Although the prognoses of noncancer diagnoses are woefully inaccurate, there seems to be far too little appreciation of the fact that the art of prognostication for cancer patients, though better, is far from an exact science and that it becomes increasingly difficult as one moves farther away from actual point of death. This is expecially the case as the prognosticator predicts outside of the last three months of life. Physicians, or at least oncologists, have become fairly accurate in predicting remaining length of life for a terminally ill cancer patient when that prognosis is made within the final quarter-year of life—although the accuracy varies somewhat by cancer site—but their accuracy falls off markedly if they try to offer a prognosis in the advance of that point. The likelihood that most initial prognoses will continue to be made by physicians who are not oncologists suggests even less overall accuracy.

Moreover—and this could be crucial—it appears that physicians tend to underestimate the number of remaining days of life of terminal cancer patients.[5] The six-month eligibility requirement was probably set, partially, to allow for this kind of unpredictability; but in setting the point this far out, framers of the program may well have encouraged greater inaccuracy. (One reason, of course, for setting it at six months is so that patients can have access to services early enough for the services to be optimally helpful to them.) Furthermore, the very uncertainty of correct prognostication at the six-months point may place physicians in a position of greater susceptibility to pressure from families or other funding sources to declare a six-month prognosis prematurely.

Point of Resignation. Premature declaration of eligibility and inaccuracy of prognosis—and hence impact on average lengths-of-stay and ultimately, costs—still could be relatively small if the current average length-of-stay of forty-five days reflects primarily some "natural point" of resignation regarding curability on the part of the terminal patient, the family, or the physician, rather than other factors such as financial or geographic access to home care. The key actors in the agonizingly real drama of trying to cure an illness, which if left uncured results in death, typically may not give up on the curative treatment of the illness in favor of a palliative approach until rather close to point of death, perhaps around four to ten weeks. In this case, demand for hospice care could be expected to remain relatively inelastic.

This situation may apply most often to persons whose illness is terminal cancer. The dying process for most other terminal diagnoses does not seem to evoke the same degree of dread and, hence, desperation in seeking a cure (nor does it usually hold as much perceived potential for recov-

ery or remission) that "dying" from terminal cancer does, so that the access considerations surrounding the use of home care may play a larger role in hospice use when other diagnoses are involved.

While the forty-five-day average has not been explained adequately by research, policymakers probably should assume that factors other than some natural resignation point play a significant, though perhaps decidedly secondary, role in explaining the length-of-stay experience to date, especially for the terminally ill with diagnoses other than cancer.

Provider Reaction and Patient Access

Should the average length of stay under Medicare-funded hospice care rise much beyond the historical forty-five-day average (on which the 40 percent reimbursement limitation under Medicare is based), hospices are likely to react to reduce their potential liability in ways that could affect rather significantly the levels of access to and quality of hospice care that the legislation was designed to raise. These responses could also occur as providers seek to lessen their liability for continuing services to persons whose remaining lifetimes exceed the 210 days of Medicare hospice care eligibility.

One reaction could be the lowering of service intensity to patients until the patient's last few days of life. A more desperate strategy, perhaps, that providers might follow would be to encourage patients to switch back to conventional care once the patients approach the end of their benefit period or once care needs appear destined to push aggregate costs over the 40 percent cap on reimbursements.

Probably the most likely behavior of providers—and it is difficult to see how regulation could control this behavior effectively—would be to restrict admissions to persons whose prognoses are shortest or, at least, to those who, according to the provider's own informal screening criteria, are almost certain of dying within the 210-day eligibility period. Such market behavior on the part of providers would function as a temporary self-correcting mechanism for increasing lengths of stay and resultant rising costs of the programs, although it holds potential for defeating the intended purpose of the legislation as well.

Burton David Dunlop, Senior Policy Analyst
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NOTES

1. Vincent Mor and Howard Birnbaum, "Medicare Legislation for Hospice Care: National Hospice Study Data" *Health Affairs* 2:2 Summer (1983):86
2. To the degree that the hospice legislation is perceived as providing an opportunity to increase Medicare coverage of home-based care for the chronically ill, generally, physicians could experience pressure to certify for hospice coverage a significant number of persons with diagnoses other than cancer. This pressure could come through state Medicaid agencies interested in shifting state costs for home care to the federal Medicare program as well as from the families of chronically ill elders currently bearing the burden of care provision.
3. This outcome would seem even more likely should any significant pressure on physicians to certify the chronically ill (who are not necessarily terminally ill) for the hospice benefit develop.
4. Mor and Birnbaum, "Medicare Legislation for Hospice Care," p. 86
5. J.W. Yates, F.P. McKegney, and L.E. Kun, "A Comparative Study of Home Nursing Care of Patients with Advanced Cancer," *Proceedings of the American Cancer Society Third National Conference on Human Values and Cancer,* 1982; 207-218