



**U.S. Department of Health and Human Services
Office of Inspector General**

Hospice Deficiencies Pose Risks to Medicare Beneficiaries

OEI-02-17-00020

July 2019

oig.hhs.gov

Joanne M. Chiedi
Acting Inspector General





Hospice Deficiencies Pose Risks to Medicare Beneficiaries

What **OIG** Found

Hospices are reviewed onsite by surveyors from either State agencies or accrediting organizations. These surveys are key to ensuring quality care. Surveyors cite the hospice with a deficiency if it fails to meet a requirement for participating in the Medicare program. From 2012 through 2016, nearly all hospices that provided care to Medicare beneficiaries were surveyed. Over 80 percent of these hospices had at least one deficiency.

The most common types of deficiencies involve poor care planning, mismanagement of aide services, and inadequate assessments of beneficiaries. In addition to these, hospices had other deficiencies that also posed risks to beneficiaries. These failings—such as improperly vetting staff and inadequate quality control—can jeopardize beneficiaries' safety and lead to poor care. Further, one-third of all hospices that provided care to Medicare beneficiaries had complaints filed against them.

Over 300 hospices had at least one serious deficiency or at least one substantiated severe complaint in 2016, which we considered to be poor performers. These hospices represent 18 percent of all hospices surveyed nation-wide in 2016. Most poor performers had other deficiencies or substantiated complaints in the 5-year period. Some poor performers had a history of serious deficiencies.

What **OIG** Recommends

The findings provide further evidence that the Centers for Medicare & Medicaid Services (CMS) should implement existing Office of Inspector General (OIG) recommendations to strengthen the survey process, establish additional enforcement remedies, and provide more information to beneficiaries and their caregivers.

We also make several new recommendations: CMS should (1) expand the deficiency data that accrediting organizations report to CMS and use these data to strengthen its oversight of hospices; (2) take the steps necessary to seek statutory authority to include information from accrediting organizations on Hospice Compare, CMS's website that contains limited information about individual hospices; (3) include on Hospice Compare the survey reports from State agencies; (4) include on Hospice Compare the survey reports from accrediting organizations, once authority is obtained; (5) educate hospices about common deficiencies and those that pose particular risks to beneficiaries; and (6) increase oversight of hospices with a history of serious deficiencies. CMS either concurred or partially concurred with all the recommendations except the third.

Key Takeaway

The majority of hospices had at least one deficiency in the quality of care they provide. It is essential that CMS take action to hold hospices accountable and protect beneficiaries and the program.

Why **OIG** Did This Review

OIG has identified significant vulnerabilities in the Medicare hospice benefit and found that hospices did not always provide needed services to beneficiaries and sometimes provided poor quality care.

Hospice care can provide great comfort to beneficiaries, their families, and other caregivers at the end of a beneficiary's life. To promote compliance and quality of care, CMS relies on State agencies and accrediting organizations to survey hospices. As part of this process, surveyors review clinical records, visit patients, and cite hospices with deficiencies when they do not meet Medicare requirements. Hospices must be surveyed at least once every 3 years. Surveyors also investigate complaints.

This report provides a first-time look at hospice deficiencies nation-wide in that it includes both hospices that were surveyed by State agencies and those surveyed by accrediting organizations. This report is the first in a two-part series. The companion report addresses beneficiary harm in depth.

How **OIG** Did This Review

We based this study on an analysis of CMS's deficiency and complaint data from 2012 through 2016. We analyzed data from State agencies and accrediting organizations. We also reviewed the survey reports from State agencies for a purposive sample of 50 serious deficiencies.

TABLE OF CONTENTS

BACKGROUND	1
Methodology	6
FINDINGS	
Over 80 percent of hospices had at least one deficiency; 20 percent had a serious deficiency	7
The most common types of deficiencies involve poor care planning, mismanagement of aide services, and inadequate assessments of beneficiaries	9
Additional deficiencies also put beneficiaries at risk	10
One-third of hospices had complaints filed against them; for almost half of these hospices, the complaints were severe	13
More than 300 hospices are poor performers	15
CONCLUSION AND RECOMMENDATIONS	
Expand the deficiency data that accrediting organizations report to CMS and use these data to strengthen its oversight of hospices	17
Take the steps necessary to seek statutory authority to include information from accrediting organizations on Hospice Compare	18
Include on Hospice Compare the survey reports from State agencies	18
Include on Hospice Compare the survey reports from accrediting organizations, once authority is obtained	19
Educate hospices about common deficiencies and those that pose particular risks to beneficiaries	19
Increase oversight of hospices with a history of serious deficiencies	19
AGENCY COMMENTS AND OIG RESPONSE	21
APPENDICES	
A. List of Conditions of Participation for the Medicare Hospice Program	23
B. Detailed Methodology	25
C. Percentage of Surveyed Hospices in Each State That Had At Least One Deficiency in the 5 Years	28
D. The 10 Most Common Types of Deficiencies	30
E. Agency Comments	31
ACKNOWLEDGMENTS	34

BACKGROUND

Objectives

1. To determine the extent to which hospices have deficiencies and the nature of these deficiencies.
2. To determine the extent to which complaints are filed against hospices and the nature of these complaints.
3. To identify hospices that are poor performers and describe their characteristics.

Hospice is an increasingly important benefit for the Medicare population. The goals of hospice care are to make terminally ill beneficiaries with a life expectancy of 6 months or less as physically and emotionally comfortable as possible, and to support their families and other caregivers throughout the process. The number of hospice beneficiaries has grown every year for the past decade. In 2017, Medicare spent \$17.8 billion for hospice care for nearly 1.5 million beneficiaries, up from \$9.2 billion for less than 1 million beneficiaries in 2006.

The Office of Inspector General (OIG) has identified significant vulnerabilities in the Medicare hospice benefit. OIG's recent portfolio, which synthesized its body of work on the Medicare hospice benefit, raised a number of concerns about the care provided to beneficiaries.¹ OIG found that hospices did not always provide needed services to beneficiaries and sometimes provided poor quality care.

OIG has also found that inappropriate billing by hospices has cost Medicare millions of dollars. In some instances, hospices bill Medicare for a higher level of care than the beneficiary needs.² Additionally, OIG has been involved in a number of hospice fraud and abuse cases. In many of these cases, hospices enrolled beneficiaries who were not terminally ill, altered patient records, falsified documentation, and billed for services not provided. In a recent example, a Mississippi doctor was given a lengthy prison sentence and ordered to pay nearly \$2 million to Medicare for

¹ This portfolio also presents recommendations to improve program vulnerabilities. See OIG, *Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio*, OEI-02-16-00570, July 2018.

² Ibid.

fraudulently referring beneficiaries to hospice.³ The doctor admitted to receiving payments in return for the referrals.

To promote compliance and quality of care, the Centers for Medicare & Medicaid Services (CMS) relies on surveyors to conduct onsite reviews of hospices. CMS contracts with State agencies and grants approval to national accrediting organizations to conduct these surveys and to investigate complaints.⁴ As part of this process, surveyors observe the operation of the hospice, review clinical records, and visit patients. Surveyors cite the hospice with a deficiency if it fails to meet a requirement for participating in the Medicare program.

This report is the first in a two-part series. It focuses on the overall quality of care provided to hospice beneficiaries and the deficiencies found by surveyors. It provides a first-time look at hospice deficiencies nation-wide in that it includes both hospices that were surveyed by State agencies and those surveyed by accrediting organizations. The companion report addresses beneficiary harm in depth.⁵ It describes specific instances of harm and identifies vulnerabilities in preventing and addressing harm.

The Medicare Hospice Benefit

To be eligible for Medicare hospice care, a beneficiary must be entitled to Medicare Part A and be certified as having a terminal illness with a life expectancy of 6 months or less if the illness runs its normal course.⁶ Upon a beneficiary's election of hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary's terminal illness and related conditions.

Hospice care is palliative, rather than curative. It includes, among other benefits, nursing care, medical social services, hospice aide services, medical supplies (including drugs and biologicals), and physician services.⁷ The beneficiary waives all rights to Medicare payment for services related to the curative treatment of the terminal condition or related conditions but retains rights to Medicare payment for services to treat conditions unrelated

³ DOJ, "Cleveland Doctor Sentenced in Hospice Fraud Case" August 14, 2017. Accessed at <https://www.justice.gov/usao-ndms/pr/cleveland-doctor-sentenced-hospice-fraud-case> on May 29, 2018.

⁴ Social Security Act §§ 1864 and 1865.

⁵ OIG, *Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm*, OEI-02-17-00021.

⁶ Social Security Act, §§ 1814(a)(7)(A) and 1861(dd)(3)(A); 42 CFR §§ 418.20 and 418.22.

⁷ Social Security Act, § 1861(dd)(1).

to the terminal illness.⁸ Beneficiaries may revoke their election of hospice care and return to standard Medicare coverage at any time.⁹

The Medicare hospice benefit has four levels of care, which are paid at different rates. The levels are routine home care, continuous home care, general inpatient care, and inpatient respite care. Each level has an all-inclusive daily rate that is paid through Part A. The rate is paid to the hospice for each day that a beneficiary is in hospice care, regardless of the number of services furnished on a particular day.¹⁰

Medicare-certified hospices provide the care. These hospices may be for-profit, nonprofit, or government-owned. Care may be provided in various settings, including the home or other places of residence, such as an assisted living facility or a nursing facility.

Survey and Certification Process

To participate in Medicare, hospices must be certified as meeting certain Federal requirements—called Conditions of Participation (CoPs). See Appendix A for a list of the CoPs. The CoPs consist of standards for health and safety.¹¹ For example, the hospice CoP for infection control includes a standard for prevention, a standard for control, and a standard for education. The requirements are intended to ensure the quality of care and services provided by hospices. Beginning in April 2015, hospices must be surveyed at least once every 3 years to verify their compliance with these requirements.¹²

Hospices choose to have their surveys conducted either by State agencies or—for a fee—by CMS-approved accrediting organizations. CMS contracts with State agencies and has granted approval to three accrediting

⁸ Social Security Act, § 1812(d)(2)(A); 42 CFR § 418.24(d).

⁹ Social Security Act, § 1812(d)(2)(B); 42 CFR § 418.28.

¹⁰ 42 CFR § 418.302. For continuous home care, the hospice is paid an hourly rate based on the number of hours of continuous care furnished to the beneficiary on that day. The daily continuous home care rate is divided by 24 hours to determine an hourly rate. A minimum of 8 hours of predominantly nursing care must be provided. CMS, *Medicare Claims Processing Manual*, Ch. 11, § 30.1.

¹¹ Social Security Act, §§ 1861(dd)(2). 42 CFR part 418, subparts C and D set forth the CoPs. The CoPs are each divided into standards which are individual requirements that address specific aspects within the CoPs.

¹² Social Security Act, § 1861(dd)(4)(C). The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) established the requirement that Medicare hospices must be surveyed at least every 3 years. Prior to the IMPACT Act, neither law nor regulation specified the frequency of Medicare surveys for hospices. See also, 42 CFR § 488.5(a)(4)(i).

organizations.¹³ The State agencies and accrediting organizations survey hospices to ensure that they comply with Federal requirements. As part of this process, surveyors gather information necessary to determine whether the hospice is providing appropriate care. For example, they conduct home visits and interviews with patients and staff, as well as observe the facility's condition and operations.¹⁴ Surveyors document their official findings in a "survey report." State agencies and accrediting organizations must have comparable survey processes.¹⁵

Deficiencies. If a hospice fails to meet a requirement, surveyors cite the hospice with a deficiency. A deficiency can be standard-level or condition-level depending on the manner and degree to which a hospice satisfies the various standards within each condition.¹⁶

Surveyors may cite a hospice with a condition-level deficiency—which is the most serious—when the hospice violates one or more standards in a way that substantially limits its capacity to furnish adequate care or adversely affects the health and safety of patients.¹⁷

Deficiencies represent violations present at the time of the survey. After a hospice is cited with a deficiency, it must submit a plan of correction to the State agency or accrediting organization, as appropriate. This plan of correction explains

Condition- and standard-level deficiencies

Condition-level: Surveyors cite a condition-level deficiency when a hospice violates one or more standards and the hospice's capacity to furnish adequate care is substantially limited or adversely affects the health and safety of patients. Condition-level deficiencies are the most serious type of deficiency.

Standard-level: Surveyors cite a standard-level deficiency when the hospice violates a standard within a condition of participation. This violation does not yet reach the level of substantially limiting the hospice's capacity to furnish adequate care or of adversely affecting the health and safety of patients.

¹³ Social Security Act, §§ 1864(a) and 1865(a)(1). The three accrediting organizations approved to conduct surveys of hospices are the Community Health Accreditation Partner, The Joint Commission, and the Accreditation Commission for Health Care, Inc. About 42 percent of Medicare hospices have their surveys conducted by accrediting organizations. See CMS, *FY 2017 Report to Congress: Review of Medicare's Program Oversight of Accrediting Organizations and the Clinical Laboratory Improvement Amendments of 1988 Validation Program*, October 4, 2018, p. 16. Accessed at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-01-RTC.pdf> on October 30, 2018.

¹⁴ CMS, *State Operations Manual (SOM)*, Appendix M.

¹⁵ 42 CFR § 488.5(a)(4)(ii).

¹⁶ 42 CFR § 488.26(b).

¹⁷ 42 CFR § 488.24(b).

how the hospice will address each deficiency, including procedures to ensure they remain corrected. It is the responsibility of the State agency or accrediting organization to determine when the deficiency is considered resolved.¹⁸

Immediate Jeopardy. Surveyors may also discover situations that constitute immediate jeopardy, meaning a hospice’s noncompliance has caused or is likely to cause serious injury, harm, impairment, or death to a patient.¹⁹ One or more condition-level deficiencies may result in immediate jeopardy.

Complaints. Beneficiaries, caregivers, and others may file complaints against hospices. CMS tracks these complaints, categorizing them into different severity levels to determine what actions to take.²⁰ Severe complaints are those at the two highest severity levels. These complaints allege situations of immediate jeopardy (i.e., likely to cause serious injury, harm, impairment, or death to a patient) or non-immediate jeopardy high priority (i.e., likely to involve substantial noncompliance with one or more CoPs).²¹ CMS requires State surveyors to conduct onsite surveys to investigate severe complaints.²² Immediate jeopardy complaints must be investigated within 2 working days and non-immediate jeopardy high-priority complaints within 45 calendar days.²³ Other complaints are not required to be investigated until the next onsite survey occurs. Surveyors from either State agencies or accrediting organizations can investigate these complaints. If surveyors find evidence supporting the complaint, they substantiate it and may cite deficiencies.²⁴

Enforcement Actions

The only enforcement action that CMS can initiate against hospices that do not correct deficiencies is termination from Medicare.²⁵ In contrast, CMS has a variety of enforcement actions available for other types of Medicare providers, such as nursing homes and home health agencies. These actions

¹⁸ 42 CFR § 488.28(a). See also, CMS, *SOM*, Ch. 2, § 2728B.

¹⁹ 42 CFR § 489.3. See also CMS, *SOM*, Appendix Q.

²⁰ CMS, *SOM*, Ch. 5, § 5010.

²¹ CMS categorizes complaints into one of eight severity levels. In this report, we consider “severe” complaints to be complaints classified at the two highest severity levels—immediate jeopardy and non-immediate jeopardy high priority. See CMS, *SOM*, Ch. 5, §§ 5075.1 and 5075.2.

²² CMS, *SOM*, Ch. 5, § 5075.9.

²³ By contrast, severe complaints filed against nursing homes must be investigated within 2 working days or 10 working days.

²⁴ CMS, *SOM*, Exhibit 23.

²⁵ 42 CFR § 489.53. See also CMS, *SOM*, Ch. 3.

include civil monetary penalties and denial of Medicare payments, among others.²⁶

Methodology

We based this study on an analysis of CMS's deficiency and complaint data from 2012 through 2016. We analyzed data from both State agencies and accrediting organizations. We determined the percentage of hospices that were surveyed and the percentage of these hospices that had at least one deficiency in each year and in the 5 years. We did this for all hospices nation-wide—including hospices that were surveyed by State agencies and those surveyed by accrediting organizations. These deficiencies represent violations present at the time of the survey. Surveyors may cite a hospice with one or more deficiencies during a survey. Also, a hospice may have more than one survey in a year. For example, a hospice may have a standard survey and then have another survey to follow up on a complaint.

We also reviewed the survey reports from State agencies for a purposive sample of 50 serious deficiencies. Lastly, we identified hospices that had at least one serious deficiency or one substantiated severe complaint in 2016. We considered these hospices to be poor performers.

See Appendix B for a detailed description of the methodology.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

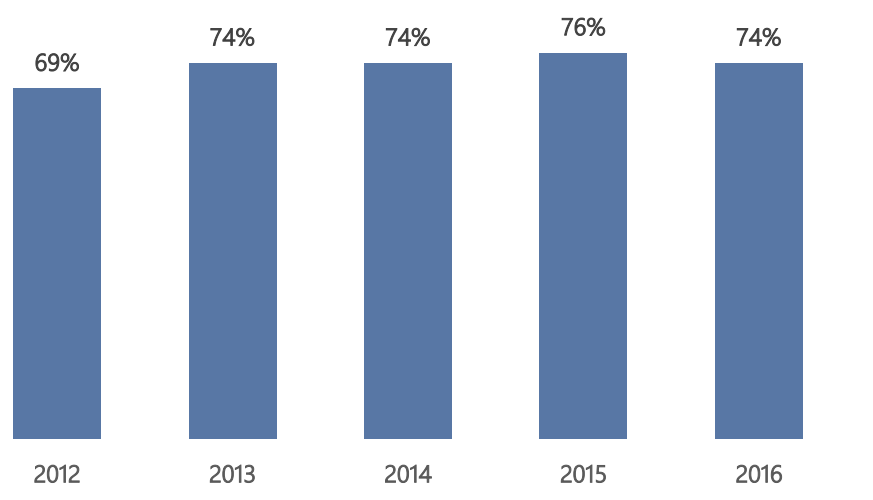
²⁶ 42 CFR § 488.406 and 42 CFR § 488.820.

FINDINGS

Over 80 percent of hospices had at least one deficiency; 20 percent had a serious deficiency

Nearly all hospices that provided care to Medicare beneficiaries were surveyed at least once from 2012 through 2016.²⁷ Eighty-seven percent of these 4,563 hospices had a deficiency during this 5-year period, meaning that they failed to meet at least 1 requirement (condition-level or standard-level) for participating in the Medicare program. These requirements are intended to ensure the quality of care and services provided by hospices. Each year, 69 percent to 76 percent of surveyed hospices had at least one deficiency. See Exhibit 1.

Exhibit 1: The percentage of surveyed hospices that had a deficiency was consistently high each year.



Source: OIG analysis of CMS data, 2018.

Hospices in some States had deficiencies at higher rates than hospices in other States. For example, 50 percent of all surveyed hospices in Maine—10 of 20—had a deficiency in the 5 years, while 99 percent of surveyed hospices in Michigan—130 of 131—had a deficiency during the same period.²⁸ See Appendix C.

Information about individual hospices' deficiencies is not available on Hospice Compare—CMS's primary website for sharing quality-of-care

²⁷ In total, 4,563 of the 4,799 hospices (95 percent) that provided care to Medicare beneficiaries were surveyed from 2012 through 2016.

²⁸ Surveyor practices may contribute to variations in rates of deficiencies. Note that this includes data from both State agencies and accrediting organizations.

information about hospices.²⁹ This information would enable beneficiaries and their caregivers to make more informed choices and would help hold hospices accountable for the care they provide.

Most hospices had multiple deficiencies

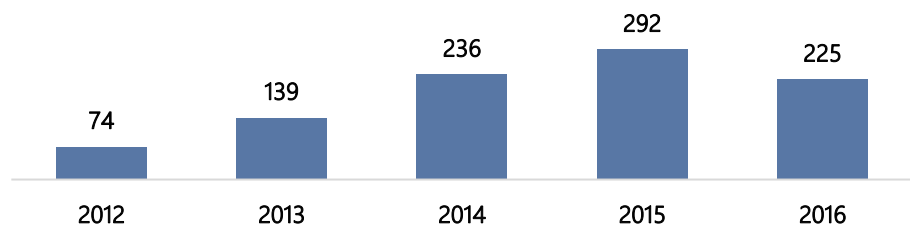
Most hospices that had a deficiency in 2016 had multiple deficiencies from 2012 through 2016 and many had multiple deficiencies within the same year.³⁰ Specifically, more than half—886 of 1,269 (70 percent)—of the hospices that had a deficiency in 2016 also had at least one other deficiency in the 5-year period.

Hospices surveyed by State agencies in 2016 had an average of four deficiencies that year. Twenty-nine percent of these hospices had at least five deficiencies that year. The number of deficiencies for each hospice surveyed by accrediting organizations is not available to conduct comprehensive analysis because accrediting organizations report this information differently to CMS.

Twenty percent of hospices had serious (condition-level) deficiencies in quality of care

Twenty percent (903 of 4,563) of hospices surveyed from 2012 through 2016 had at least one serious deficiency—a condition-level deficiency—which means that the hospice’s capacity to furnish adequate care was substantially limited, or the health and safety of beneficiaries were in jeopardy. The number of hospices with these deficiencies nearly quadrupled from 2012 to 2015—going from 74 to 292—then decreased somewhat in 2016. See Exhibit 2.

Exhibit 2: The number of surveyed hospices that had a serious deficiency nearly quadrupled from 2012 through 2015 before decreasing somewhat in 2016.



Source: OIG analysis of CMS data, 2018.

²⁹ See OIG, *Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio*, OEI-02-16-00570, July 31, 2018.

³⁰ A hospice may have more than one survey in a year. For example, a hospice may have a standard survey and then also have another survey to follow up on a complaint. During each survey, the hospice may be cited with one or more deficiencies.

Twenty-eight hospices had at least one immediate jeopardy situation during the 5-year period. When a hospice is cited with immediate jeopardy, it means that the hospice did not meet one or more requirements that caused, or is likely to cause, serious injury, harm, impairment, or death to a beneficiary.

The most common types of deficiencies involve poor care planning, mismanagement of aide services, and inadequate assessments of beneficiaries

From 2012 through 2016, hospices most commonly had deficiencies related to care planning, hospice aide services, and patient assessments. These areas are essential to delivering quality care to beneficiaries. See Appendix D for the list and frequencies of the 10 most common types of deficiencies.

Almost 60 percent of hospices surveyed failed to meet all care planning requirements

Fifty-nine percent of the hospices surveyed from 2012 through 2016 had deficiencies related to care planning. Hospices must develop individualized care plans for every beneficiary they serve and provide services that meet the plan.³¹ Proper care planning helps ensure that beneficiaries receive the care and attention they need.

Many hospices with care planning deficiencies failed to ensure that they provided the services called for in the care plans that they established. For example, one hospice did not provide nurse visits for two consecutive weeks despite a beneficiary's care plan ordering weekly nurse visits. Also, for at least 5 weeks, the nurse did not follow the care plan to assess the beneficiary's gastrostomy tube site or colostomy stoma at each visit.

Examples of poor care planning included:

- Providing fewer services than called for in the care plan
- Failing to address individual needs

Hospices also failed to ensure that the care plans were appropriately individualized. For example, one hospice did not address the needs of a beneficiary with dysphagia who had to be fed very slowly with small bites due to frequent choking.

More than half of hospices surveyed did not properly train or manage their aide staff

Fifty-three percent of the hospices surveyed in the 5 years had deficiencies related to hospice aide and homemaker services. Hospice aides serve a key role in the delivery of care to beneficiaries.

³¹ 42 CFR § 418.56.

Many of these hospices failed to ensure that hospice aides were supervised or given patient-specific care instructions. In one example, a hospice nurse did not perform the required supervisory visits to assess the aide services.

Examples of mismanagement of aide services included:

- Not supervising aides
- Failing to train aides

Some of these hospices did not ensure that hospice aides were competent to provide care. For example, one hospice failed to ensure that three of four aides had the appropriate skills in toileting and transfer techniques to provide care to beneficiaries.

More than 40 percent of hospices surveyed assessed beneficiaries inadequately

Forty-two percent of the hospices surveyed in the 5 years had deficiencies related to patient assessments. The care provided to a beneficiary is dictated by the hospice's assessment of the beneficiary. Without timely or thorough assessments, beneficiary and family needs may be overlooked or inadequately addressed.

Many of these hospices failed to include key content in the comprehensive assessments. In one example, the hospice did not review beneficiaries' drug profiles to monitor medication effectiveness or check for possible side effects during updates to comprehensive assessments. In some cases, hospices failed to assess the beneficiaries' history of pain.

Examples of inadequate assessments included:

- Failing to monitor medications
- Not assessing pain
- Failing for months to update comprehensive assessments

Hospices also failed to update assessments within the required timeframe. Comprehensive assessments should be conducted at least every 15 days, or as frequently as the patient's condition requires.³² In one example, three beneficiaries were each in hospice care for more than 5 months and the hospice did not update their assessments during that entire time.

Additional deficiencies also put beneficiaries at risk

In addition to the common deficiencies discussed above, hospices had other deficiencies that also posed risks to beneficiaries. When hospices have deficiencies, beneficiaries' care may suffer. This is especially true of serious

³² 42 CFR § 418.54(d).

deficiencies, which is when the hospice violates one or more standards that substantially limit its capacity to furnish adequate care or adversely affects the health and safety of beneficiaries. A review of 50 selected serious deficiencies from 2016 reveals situations that pose significant risks to hospice beneficiaries. These situations are discussed below.³³

Some hospices did not properly vet their staff, putting beneficiaries' safety at risk

Some hospices did not complete criminal background checks of staff, while other hospices did not update employee credentials. When hospices fail to ensure that staff are qualified, they put the safety of beneficiaries at risk.

For example, one hospice did not obtain criminal background checks on six employees who provided direct patient care or had access to patient records.

Another hospice failed to ensure that 34 of its 35 employees who provided care had updated credentials in accordance with State and local laws. Eighteen employees were not screened for abuse and neglect prior to working at the facility and three did not have required professional licensure.

Hospices did not always address needs, putting some beneficiaries at risk of suffering unnecessary pain and distress

Hospices sometimes failed to provide needed services, which put beneficiaries at risk of suffering unnecessary pain and discomfort.

In one example, a hospice did not ensure that a beneficiary's pain was assessed and managed in a timely manner. Although the beneficiary was given medication to treat the pain, the pain continued to escalate, and several days passed before the beneficiary was reassessed.

Another hospice did not measure for several weeks a beneficiary's Stage IV

Examples of improper vetting of staff included:

- Failing to obtain criminal background checks
- Not ensuring staff had proper credentials

Examples of not addressing needs included:

- Failing to effectively manage pain
- Not properly treating severe wounds
- Failing to provide volunteer services

³³ The companion report to this one addresses beneficiary harm in depth. See OIG, *Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm*, OEI-02-17-00021.

pressure ulcer—the most severe type—despite having a policy stating that wounds were to be measured weekly at minimum. In addition, the hospice did not follow the physician’s orders to treat the wound.

Further, another hospice failed to provide needed volunteer services to several beneficiaries. All hospices are required to use volunteers. These volunteers provide services to beneficiaries who need them. The services include spending time with beneficiaries and assisting with daily activities. One beneficiary waited about 8 months for volunteer services.

Some hospices did not coordinate beneficiaries’ care, at times keeping their physicians uninformed

Hospices sometimes failed to coordinate and inform staff about a beneficiary’s condition and needed services. This failure puts beneficiaries at risk of not receiving appropriate and timely care.

For example, nurses at one hospice did not notify the physician of their failed attempts over 2 days to perform an intravenous insertion. At another hospice, a nurse did not notify the physician of the beneficiary’s escalating pain or his use of a higher amount of pain medication. The beneficiary was taking double the dose of fentanyl ordered on the care plan.

Examples of lack of coordination included:

- Failing to notify physician of symptoms
- Not having contracts with needed inpatient facilities

Moreover, hospices sometimes failed to coordinate care with other facilities, such as skilled nursing facilities. Hospices often work with these facilities when a beneficiary needs short-term inpatient care. To meet a beneficiary’s needs, the hospice and facility should have a shared understanding of each other’s responsibilities for the beneficiary’s care.

Specifically, one hospice used a local hospital for short-term inpatient care but did not have a contract with the provider, as required. At another hospice, the written agreement with a nursing facility was missing key elements, leading to problems with the coordination of care. The hospice and nursing facility did not have the same medication and treatment order for one beneficiary. They also had a history of refusing to collaborate. Another hospice failed to maintain contracts with other facilities to provide other levels of hospice care—general inpatient and inpatient respite—as required.

Not all hospices maintained quality control programs, creating possible hazards

Some hospices failed to maintain required programs that help ensure quality care and services. Without these quality control programs, hospices cannot systematically identify and evaluate risk to improve the care and services provided to beneficiaries.

For example, one hospice did not maintain a quality assessment and performance improvement program. It failed to analyze beneficiaries' falls to prevent future occurrences.

Examples of inadequate quality control included:

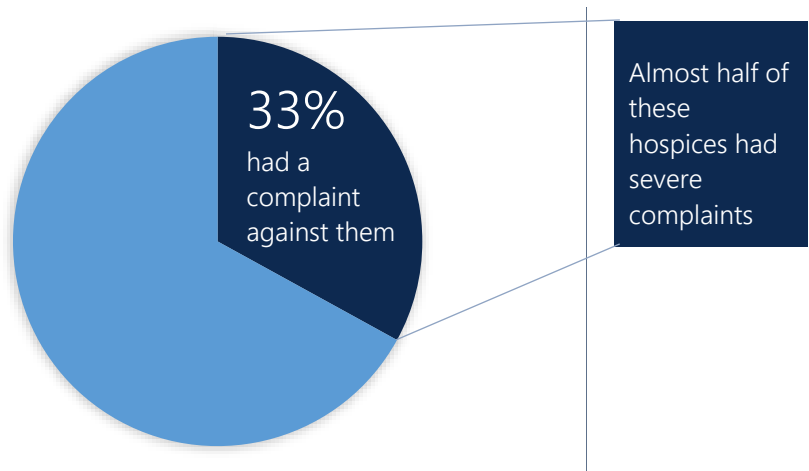
- Not preventing falls
- Not tracking infections

Another hospice failed to maintain an infection control program. Specifically, the hospice did not track staff infections or complete incident reports for patient infections.

One-third of hospices had complaints filed against them; for almost half of these hospices, the complaints were severe

From 2012 through 2016, one-third of all hospices that provided care to Medicare beneficiaries had complaints filed against them.³⁴ Many of the complaints were severe.

Exhibit 3: One-third of hospices had complaints filed against them, and for almost half of these hospices, the complaints were severe.



Source: OIG analysis of CMS data, 2018.

In each year, 11 to 14 percent of hospices had complaints filed against them. The most common complaints were about quality of care, patient's rights, and administration issues. These complaints include beneficiaries not

³⁴ In total, 1,574 of the 4,799 hospices that provided care to Medicare beneficiaries had complaints filed against them from 2012 through 2016.

receiving treatment to control pain and manage symptoms, beneficiaries not receiving a notice of patient's rights in a language they understand, and unqualified hospice administrators. Other types of complaints were related to nursing services, patient neglect, and pharmaceutical services.

Almost half of the hospices that had a complaint filed against them had multiple complaints over the 5 years. Specifically, 1,574 hospices had at least one complaint filed against them from 2012 through 2016, and 741 of these hospices had multiple complaints. Notably, one hospice in Florida had a total of 70 complaints filed against it—10 each in 2012, 2013, and 2014; and 20 each in 2015 and 2016. Another hospice in Texas had 12 complaints filed against it in 2016 alone. Numerous complaints against the same hospice raise concerns that it may have systemic problems.³⁵

Thirty-two percent of the complaints filed against hospices in the 5 years were substantiated.³⁶ For a complaint to be substantiated, a surveyor must find evidence that verifies the complainant's concern. It is important to note that these investigations can take place months or even years after the complaint is filed. Some complaints are not required to be investigated until the next onsite survey occurs, which can affect whether a complaint is substantiated.

More than 700 hospices had severe complaints filed against them

For almost half the hospices that had a complaint filed against them in the 5 years (719 of 1,574 hospices), the complaint was classified as severe. This means that the hospice allegedly failed to meet one or more requirements that could result in substantial noncompliance, or may have more grievous results such as serious injury, impairment or even death to a beneficiary.

Notably, the number of hospices that had severe complaints filed against them grew each year, more than tripling from 78 to 285 from 2012 to 2016. This increase may indicate a growing risk to an already vulnerable population.

In total, 1,143 severe complaints were filed against hospices during the 5-year timeframe, and 35 percent of these complaints were substantiated.³⁷

³⁵ CMS, *SOM*, Ch. 5, § 5000.1.

³⁶ A total of 3,686 complaints were filed and 1,190 of them were substantiated.

³⁷ Severe complaints consist of immediate jeopardy and non-immediate jeopardy high priority. Immediate jeopardy complaints must be investigated within 2 working days and non-immediate jeopardy high-priority complaints within 45 calendar days. See CMS, *SOM*, Ch. 5, § 5075.9.

More than 300 hospices are poor performers

We identified 313 hospices as poor performers. Each of these hospices were surveyed and had at least one serious deficiency or one substantiated severe complaint in 2016. These hospices represent 18 percent of all hospices surveyed nation-wide in 2016. Together, they billed Medicare \$1.6 billion for care provided to over 135,000 beneficiaries that year.

The poor performers were located throughout the Nation. Texas and California had the most, with 45 and 39, respectively. Missouri and South Carolina had the next highest numbers.

Most of the poor performers—275 or 88 percent—had a history of other violations. Each of these hospices had at least one other deficiency or substantiated complaint in the 5 years.³⁸ About half of these hospices had deficiencies or substantiated complaints in multiple years.

For-profit hospices account for a higher percentage of poor performers than nonprofits do. The percentages are similar to the distribution of Medicare hospices in general. For-profit hospices represent 67 percent of poor performers, compared to 64 percent of all Medicare hospices. Nonprofit hospices account for 21 percent of the poor performers, and 23 percent of all Medicare hospices.

A few dozen poor performers particularly stand out for having a history of serious deficiencies. These 40 hospices, in addition to having a serious deficiency or severe complaint in 2016, each had other serious deficiencies in the 5 years. For example, one hospice in Idaho had serious deficiencies in three consecutive years. Another hospice in Missouri had serious deficiencies about 3 months apart in 1 year alone. These patterns may indicate that these hospices are not addressing underlying systemic problems that are giving rise to repeated cycles of serious deficiencies.

Characteristics of poor performers

- 88 percent had a history of other violations
- 67 percent were for-profit, similar to hospices nation-wide
- 40 hospices had a history of serious deficiencies

³⁸ These other deficiencies include standard- and condition-level deficiencies.

CONCLUSION AND RECOMMENDATIONS

The use of hospice care has increased considerably over the past decade. Medicare payments for this care and the number of hospices have also grown steadily. CMS is responsible for ensuring that hospices comply with Federal requirements and provide quality care. CMS relies on State agencies and accrediting organizations to verify hospices' compliance through onsite surveys and complaint investigations.

From 2012 through 2016, 87 percent of surveyed hospices had deficiencies in the quality of care they provided. The most common deficiencies involved poor care planning, mismanagement of aide services, and inadequate assessments. Additional deficiencies also put beneficiaries at risk. For instance, some hospices did not properly vet their staff, putting beneficiaries' safety at risk.

One-third of all hospices that provided care to Medicare beneficiaries had complaints filed against them. More than 300 hospices were poor performers in that each had at least one serious deficiency or at least one substantiated severe complaint in 2016. Most poor performers also had other deficiencies or substantiated complaints in the 5-year period. Some had a history of serious deficiencies.

This report provides a first-time look at hospice deficiencies nation-wide in that it includes both hospices that were surveyed by State agencies and those surveyed by accrediting organizations. The findings make clear the need for CMS to strengthen its oversight of the Medicare hospice program to better protect both the program and its beneficiaries. OIG previously recommended that CMS strengthen the survey process, seek statutory authority to establish additional enforcement remedies, and provide information to beneficiaries and their caregivers to help them make informed choices about their care.³⁹ OIG is working with CMS to promote the implementation of these recommendations.

³⁹ OIG, *Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio*, OEI-02-16-00570, July 2018.

Recommendations from prior OIG work that address these findings

CMS should:

1. Analyze claims data to inform the survey process
2. Analyze the deficiency data to inform the survey process
3. Seek statutory authority to establish additional, intermediate remedies for poor hospice performance
4. Include on Hospice Compare deficiency data from surveys, including information about complaints filed and resulting deficiencies

In addition, we make several new recommendations. We are committed to working with CMS to strengthen the survey process and improve quality of care in hospices. We will provide additional information to CMS about the hospices that have a history of serious deficiencies to assist with CMS's efforts.

Specifically, we recommend that CMS:

Expand the deficiency data that accrediting organizations report to CMS and use these data to strengthen its oversight of hospices

As noted earlier, the number of deficiencies for each hospice surveyed is reported differently by accrediting organizations and State agencies. CMS should expand the information about hospice deficiencies that accrediting organizations report to CMS to make it more comparable to the data reported by State agencies.

CMS should also use the deficiency data from accrediting organizations in combination with deficiency data from State agencies—as we have done in this report—to identify and address problems in hospice care. It is not possible to get an accurate picture of the quality of care and services provided to hospice beneficiaries nation-wide without data from both sources, given that more than 40 percent of hospices use accrediting organizations for their surveys.

In particular, CMS should identify hospices with persistent problems, such as those with high numbers of deficiencies in multiple years. CMS should also track basic measures and identify—on a national scale—issues and trends that warrant further examination across all hospices. For example, CMS could track the number of hospices that have multiple deficiencies in specific areas such as care planning. This and other measures would give CMS valuable tools to conduct effective oversight and to focus resources on addressing the most pressing issues with hospices.

Take the steps necessary to seek statutory authority to include information from accrediting organizations on Hospice Compare

CMS does not include deficiency data on its Hospice Compare website.⁴⁰ As we recommend in the portfolio, CMS should add to Hospice Compare deficiency data from both State survey agencies and accrediting organizations. In response to this recommendation, CMS stated that it is statutorily prohibited from publicly releasing information on any surveys conducted by accrediting organizations unless the information relates to an enforcement action.⁴¹

CMS should seek statutory authority to provide publicly information from surveys conducted by accrediting organizations. Specifically, CMS should provide on Hospice Compare deficiency data and, as discussed below, the survey reports from accrediting organizations. This would inform beneficiaries about hospices that have provided poor care. Beneficiaries and their families need this information to make good care choices at the end of life. This critical information should be available for all hospices.

CMS has made a commitment to provide more transparency about accrediting organizations and recently released data about their performance.⁴² Providing information about the deficiencies found by accrediting organizations would represent the next steps in promoting transparency.

Include on Hospice Compare the survey reports from State agencies

CMS should provide on Hospice Compare the individual survey reports from State agencies so beneficiaries and caregivers can have more in-depth information about the quality of care provided by each hospice. CMS makes survey reports available on Compare websites for other providers, including nursing homes and hospitals. Of note, CMS is required to make survey reports from State agencies publicly available.⁴³ Making this information for hospices more readily available—and accessible—in a user-

⁴⁰ CMS, *Hospice Compare*. Accessed at <https://www.medicare.gov/hospicecompare/> on October 16, 2018.

⁴¹ CMS may also disclose information on surveys for home health agencies. See 42 CFR § 401.133(d)-(e); 42 U.S.C. § 1395bb(b).

⁴² CMS, *Quality, Certification and Oversight Reports*. Accessed at <https://qcor.cms.gov/main.jsp> on November 13, 2018.

⁴³ CMS is required to make State survey reports publicly available at the CMS regional office servicing the area in which the hospice is located. 42 CFR 401.133(a) and 42 CFR 401.130(b)(17).

friendly way will provide further transparency and support the delivery of high-quality care for beneficiaries.

Include on Hospice Compare the survey reports from accrediting organizations, once authority is obtained

CMS should provide on Hospice Compare the individual survey reports from accrediting organizations, once statutory authority is obtained. As with survey reports from State agencies, those from accrediting organizations provide in-depth information about the quality of care provided by each hospice. This quality and safety information is crucial for beneficiaries and caregivers to have when choosing a hospice. CMS recognizes this and has stated that it is important to make information found in survey reports publicly available through provider Compare sites.⁴⁴ CMS has also stated that it is critical that accrediting organizations make available publicly all survey reports.

Educate hospices about common deficiencies and those that pose particular risks to beneficiaries

Hospices commonly have deficiencies related to areas that are fundamental to providing quality care. These include care planning, aide services, and patient assessments. CMS should educate hospices about the requirements associated with these areas. The training should reiterate the need to develop and follow care plans that are based on thorough and timely assessments. The training should also reiterate the need to supervise hospice aides and to meet all requirements in conducting patient assessments. Moreover, hospices had other deficiencies that warrant attention. To protect beneficiaries, CMS should educate hospices about the importance of properly vetting staff, thoroughly addressing care needs, appropriately coordinating care, and maintaining effective quality control programs. CMS could do this through methods such as conferences and webinars.

Increase oversight of hospices with a history of serious deficiencies

CMS should develop a special initiative to identify and target hospices with a history of serious deficiencies. As part of this initiative, it should provide education and technical assistance, and it should increase the frequency of surveys for these hospices to help stimulate improvement. CMS could model its efforts on the Special Focus Facility Program that CMS developed

⁴⁴ 82 Fed. Reg. 19796, 20144 (April 28, 2017). Accessed at <https://www.govinfo.gov/content/pkg/FR-2017-04-28/pdf/2017-07800.pdf> on March 7, 2019.

for nursing facilities.⁴⁵ By providing increased scrutiny, CMS can help to ensure that these hospices address underlying systemic problems that give rise to repeated cycles of serious deficiencies. This would also help to ensure that these hospices are consistently providing quality care to beneficiaries. We will provide CMS a list of the hospices we identified as having a history of serious deficiencies. CMS should include these and others it may identify in its initiative.

⁴⁵ CMS, "Fiscal Year (FY) 2017 Special Focus Facility (SFF) Program Update," March 2, 2017. Accessed at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-20.pdf> on October 5, 2018.

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred or partially concurred with all except the third of our six new recommendations. CMS concurred with our first recommendation, stating that it will work to enhance the current information about hospice deficiencies that accrediting organizations report and use it to strengthen oversight of hospices.

CMS partially concurred with our second recommendation to seek statutory authority to include information from accrediting organizations on Hospice Compare. CMS stated that the President's FY2020 Budget includes a proposal to improve safety and quality of care by revising the statute to allow CMS to publicly disclose surveys for all accredited facilities, including hospices. Making this information publicly available is important to help beneficiaries and their families make good care choices.

CMS did not concur with our third recommendation to include on Hospice Compare the survey reports from State agencies. CMS stated that while it supports increased transparency of hospice survey findings, publicly reporting survey reports only from State agencies—while CMS is currently prohibited from sharing information from surveys by accrediting organizations—may be misleading to consumers when researching hospice options. We note that the survey reports from State agencies are currently required to be publicly available. We urge CMS to make these reports more readily available and accessible on Hospice Compare. In the interests of transparency and clarity, CMS could post an explanation about why similar information is not available for hospices surveyed by accrediting organizations.

CMS partially concurred with our fourth recommendation to include on Hospice Compare the survey reports from accrediting organizations, once statutory authority is obtained. CMS stated that if authority is obtained to publicly disclose the accrediting organization survey reports, CMS would evaluate the best approach for including these reports, or the most relevant information from these reports, for consumers on CMS websites. CMS noted that it would also need to examine available resources and funding to establish these actions. As CMS described, Hospice Compare is key to giving beneficiaries, their families, and their caregivers the resources they need to make informed decisions. This makes Hospice Compare an appropriate location for centralizing access to survey reports.

CMS concurred with our fifth recommendation, stating that it will continue to educate hospices about common deficiencies through various channels. CMS also stated that it will educate hospices on the importance of vetting staff, addressing care needs, coordinating care, and maintaining quality controls as they relate to the hospices' conditions of participation.

CMS concurred with our sixth recommendation to increase oversight of hospices with a history of serious deficiencies. However, CMS stated that establishing a special focus initiative for hospice presents significant challenges as it has limited survey and certification resources. We continue to emphasize the value of analyzing survey data—as we do in this report—to identify hospices with recurring serious deficiencies and targeting CMS’s oversight efforts to better safeguard the health, welfare, and safety of all beneficiaries in hospice. We further note the value of having an initiative that focuses on hospices with persistent problems.

For the full text of CMS’s comments, see Appendix E.

APPENDIX A: List of Conditions of Participation for the Medicare Hospice Program

CFR Citation	Conditions of Participation	Description	
1	§418.52	Patient's Rights	The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.
2	§418.54	Initial and Comprehensive Assessment of the Patient	The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.
3	§418.56	Interdisciplinary Group, Care Planning, and Coordination of Services	The hospice must designate an interdisciplinary group or groups as specified in this CoP which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient. The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.
4	§418.58	Quality Assessment and Performance Improvement	The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program.
5	§418.60	Infection Control	The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.
6	§418.62	Licensed Professional Services	Licensed professional services provided directly or under arrangement must be authorized, delivered, and supervised only by healthcare professionals who meet the appropriate qualifications.
7	§418.64	Core Services	A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice.
8	§418.66	Nursing Services Waiver of Requirement That Substantially All Nursing Services Be Routinely Provided Directly by a Hospice	In certain circumstances, CMS may waive the requirement that a hospice provide nursing services directly.
9	§418.70	Furnishing of Non-core Services	A hospice must ensure that the services described in §418.72 through §418.78 are provided directly by the hospice or under arrangements made by the hospice as specified in §418.100. These services must be provided in a manner consistent with current standards of practice.
10	§418.72	Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP)	Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.
11	§418.74	Waiver of Requirement—PT, OT, SLP, and Dietary Counseling	In certain circumstances, a hospice may submit a written request for a waiver of the requirement for providing physical therapy, occupational therapy, speech-language pathology, and dietary counseling services.

continued on next page

APPENDIX A (continued)

CFR Citation		Conditions of Participation	Description
12	§418.76	Hospice Aide and Homemaker Services	All hospice aide services must be provided by individuals who meet the personnel requirements specified in this CoP. Homemaker services must be provided by individuals who meet the personnel requirements specified in this CoP.
13	§418.78	Volunteers	The hospice must use volunteers to the extent specified in this CoP. These volunteers must be used in defined roles and under the supervision of a designated hospice employee.
14	§418.100	Organization and Administration of Services	The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers, and families necessary for the palliation and management of the terminal illness and related conditions.
15	§418.102	Medical Director	The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with the hospice.
16	§418.104	Clinical Records	A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff.
17	§418.106	Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment (DME)	Medical supplies and appliances; durable medical equipment; and drugs and biologicals related to the palliation and management of the terminal illness and related conditions, must be provided by the hospice while the patient is under hospice care.
18	§418.108	Short-term Inpatient Care	Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating Medicare or Medicaid facility.
19	§418.110	Hospices that Provide Inpatient Care Directly	A hospice that provides inpatient care directly in its own facility must demonstrate compliance with all standards in this CoP.
20	§418.112	Hospices that Provide Hospice Care to Residents of a Skilled Nursing Facility/Nursing Facility (SNF/NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	A hospice that provides hospice care to residents of a SNF/NF or ICF/IID must abide by additional standards in this CoP.
21	§418.114	Personnel Qualifications	Professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of his or her State license, or State certification, or registration. All personnel qualifications must be kept current at all times.
22	§418.116	Compliance with Federal, State, and Local Laws and Regulations Related to the Health and Safety of Patients	The hospice and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations related to the health and safety of patients. If State or local law provides for licensing of hospices, the hospice must be licensed.

Source: CMS, SOM, Appendix M—Guidance to Surveyors: Hospice.

APPENDIX B: Detailed Methodology

We based this study on an analysis of deficiency and complaint data from 2012 through 2016. We analyzed data from both State agencies and accrediting organizations. We also reviewed the survey reports from State agencies for a purposive sample of 50 serious deficiencies.

Analysis of the Extent of Deficiencies

We first determined the extent to which hospices that were surveyed from 2012 through 2016 by State agencies or accrediting organizations had deficiencies. The deficiency data for hospices surveyed by State agencies are contained in the Certification and Survey Provider Enhanced Reports (CASPER). Deficiency data for hospices surveyed by accrediting organizations are contained in the Accrediting Organization System for Storing User Related Experiences. We based the analysis on hospices that provided care to Medicare beneficiaries.⁴⁶

We determined the percentage of hospices that were surveyed and the percentage of these hospices that had at least one deficiency for each year and in the 5 years. We also calculated the percentage of hospices surveyed in each State that had a deficiency in the 5 years.⁴⁷ We then determined the number of hospices that had a deficiency in 2016 and had other deficiencies in the 5 years. We identified the States in which these hospices were located to determine whether these hospices were concentrated in certain geographic areas.

Next, we calculated the average number of deficiencies for each hospice and determined the percentage of hospices that had five or more deficiencies each year. We limited this analysis to hospices surveyed by State agencies because accrediting organizations report information about deficiencies differently to CMS.

Lastly, we determined the number and percentage of surveyed hospices that had serious deficiencies (i.e., at least one condition-level deficiency) in the 5 years. We also calculated the number of these hospices that had an immediate jeopardy situation in the 5 years.

⁴⁶ We based the analysis on total number of hospices that billed Medicare. We used the Part A hospice claims from the National Claims History file to determine the total number of hospices that billed Medicare from 2012 through 2016.

⁴⁷ Throughout this report, we use the term “States” to refer to the 50 States, the District of Columbia, and Puerto Rico.

Analysis of the Nature of Deficiencies

To describe the nature of the deficiencies, we identified the most common types of deficiencies in the 5 years. To do this, we analyzed the data from State agencies and from accrediting organizations to determine the percentage of hospices surveyed that had a deficiency in each CoP category (e.g., care planning). Each CoP category typically includes multiple standards for which surveyors can cite a hospice with a deficiency.

Review of Sampled Deficiencies

To further describe the nature of deficiencies, we reviewed the survey reports for a sample of serious deficiencies. To do this, we selected a purposive sample of 50 serious deficiencies. We used the State agency data to identify one to three serious deficiencies associated with each of the CoP categories to obtain a wide range of deficiencies.⁴⁸

We then requested the corresponding survey reports from CMS. We reviewed these reports for each of the 50 serious deficiencies. We used the information about the sampled deficiencies to further describe the nature of the specific deficiencies cited within the most common CoP categories. We also used this information to identify additional problems that pose risks to beneficiaries.

Analysis of Complaints

We analyzed complaint data to determine the extent to which complaints were filed against hospices that provided care to Medicare beneficiaries and the nature of these complaints in each year and the 5 years. The complaint data are contained in the Automated Survey Processing Environment (ASPEN) Complaints/Incidents Tracking System.

We first calculated the number and percentage of hospices that had at least one complaint filed against them. Then, we determined the States in which these hospices were located. We also identified hospices that had multiple complaints filed against them during the 5 years. Next, we described the types of complaints filed against hospices. We also calculated the number and percentage of complaints that were substantiated.

Lastly, we analyzed the complaints classified as severe (i.e., complaints at the two highest severity levels).⁴⁹ Specifically, we determined for each year and in the 5 years the number and percentage of hospices with complaints that

⁴⁸ We included all but 3 of the 22 CoP categories; we did not include these 3 CoP categories because there were no serious deficiencies cited in these categories in 2016.

⁴⁹ We considered severe complaints to be complaints classified at the two highest severity levels—immediate jeopardy and non-immediate jeopardy high priority.

were classified as severe. We also determined how many of the severe complaints were substantiated in the 5 years.

Analysis of Hospices That Were Poor Performers

We identified all hospices that had at least one serious deficiency or one substantiated severe complaint in 2016. We considered these hospices to be poor performers.

Next, we determined whether poor performers were located in certain geographic areas. We also determined whether poor performers had a history of other violations (i.e., had other deficiencies or substantiated complaints in the 5 years). In addition, we examined whether they had a history of serious deficiencies. Lastly, we analyzed the extent to which these hospices varied by ownership status (e.g., for-profit), using information contained in CASPER.

APPENDIX C: Percentage of Surveyed Hospices in Each State That Had At Least One Deficiency in the 5 Years

State	Number of Surveyed Hospices	Percentage of Surveyed Hospices That Had At Least One Deficiency
Maine	20	50%
Kentucky	24	54%
Mississippi	115	59%
Massachusetts	71	63%
New Mexico	44	64%
Utah	100	70%
Tennessee	57	72%
Oregon	38	74%
Pennsylvania	205	75%
New Hampshire	22	77%
South Dakota	14	79%
Kansas	75	80%
Louisiana	131	81%
Wyoming	16	81%
Montana	27	81%
Nebraska	38	82%
Georgia	224	83%
Ohio	146	84%
Arkansas	52	87%
Arizona	119	87%
Texas	573	87%
South Carolina	101	87%
Virginia	95	87%
Missouri	124	89%
Wisconsin	73	89%
Idaho	48	90%

(continued on next page)

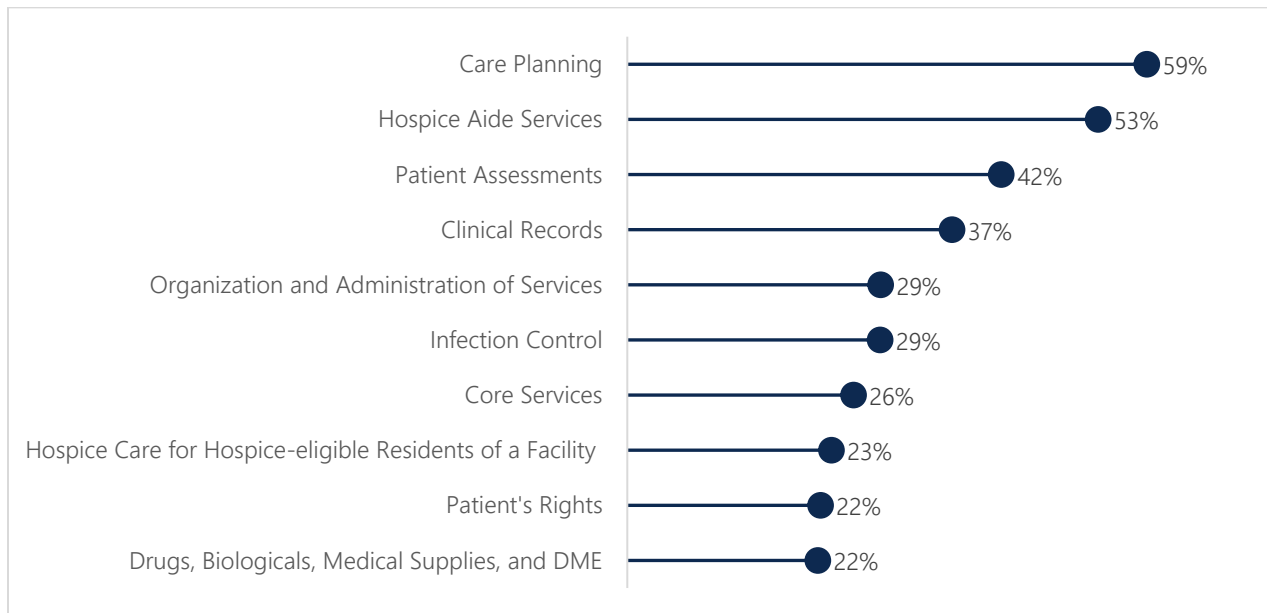
APPENDIX C (continued)

State	Number of Surveyed Hospices	Percentage of Surveyed Hospices That Had At Least One Deficiency
North Dakota	11	91%
Nevada	36	92%
Maryland	26	92%
Minnesota	73	93%
Indiana	88	93%
New York	46	93%
Connecticut	32	94%
Washington	33	94%
California	723	94%
Illinois	128	95%
Alabama	114	95%
New Jersey	57	95%
Oklahoma	134	95%
Iowa	79	95%
West Virginia	20	95%
Florida	44	95%
Colorado	68	97%
Puerto Rico	41	98%
North Carolina	81	99%
Michigan	131	99%
Vermont	10	100%

Note: We excluded Hawaii, Alaska, Delaware, the District of Columbia, and Rhode Island because they had less than 10 hospices surveyed from 2012 through 2016.

Source: OIG analysis of CMS data, 2018.

APPENDIX D: The 10 Most Common Types of Deficiencies



Note: The percentage is based on the number of hospices surveyed from 2012 through 2016 (N=4,563). These categories are based on the CoPs. For the full name of each of the CoPs, see CMS, *SOM*, Appendix M.

Source: OIG analysis of CMS data, 2018.

APPENDIX E: Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES


Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: MAY 28 2019

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator 

SUBJECT: Office of Inspector General (OIG) Draft Report: Hospice Deficiencies Pose Risks to Medicare Beneficiaries (OEI-02-17-00020)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to providing Medicare beneficiaries in hospice care with high-quality care.

CMS oversees hospice providers through the survey and certification process. State agencies and national accrediting organizations are required to conduct surveys of hospices to ensure they provide all required services and meet all hospice conditions of participation before hospices are certified for participation in Medicare and at least every three years thereafter. In addition, beneficiaries, caregivers, and others may file complaints against hospices at any time. State agencies and accrediting organizations will prioritize and investigate such complaints, including through conducting onsite surveys, based on the seriousness of the allegations. CMS has worked to strengthen and improve hospice surveys to ensure that beneficiaries receive quality care. For example, CMS regularly provides training for hospice surveyors to ensure they are familiar with certification requirements.

CMS is empowering beneficiaries, their families, and their caregivers by giving them the resources they need to make informed decisions, and key to our effort is the Hospice Compare website. Hospice Compare reports information on Medicare-certified hospices across the nation and allows patients, family members, and health care providers to get a snapshot of the quality of care each hospice provides. Hospice Compare also includes important and useful links to hospice related information like hospice providers and suppliers who are terminated or at risk of being terminated from Medicare. More recently, CMS initiated several program changes to increase the transparency of health and safety findings at healthcare facilities, including making the Hospice Quality Reporting Program data more transparent through reporting on Hospice Compare. The Hospice Quality Reporting Program data in Hospice Compare includes quality measures that relate to the care provided by hospice providers across the country in addition to information on the experiences of patients and their primary caregivers. The Hospice Quality Reporting Program data is updated quarterly to provide timely data.

An important element of CMS efforts on improving the quality of hospice care includes outreach and education for hospice providers and surveyors. We do this through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly

compliance newsletters. CMS coordinates the Hospice Open Door Forum, which occurs every six weeks, to provide continuing education to providers and to reinforce CMS requirements. CMS also provides training on our Integrated Surveyor Training Website that is accessible to providers and surveyors. In 2019, CMS will launch the Quality, Safety & Education Portal (QSEP) which is a new and dynamic training portal providing self-service, mobile-friendly, on-demand training to users at any time to provide surveyors with the knowledge and skills needed to make decisions that ensure health and safety for Medicare beneficiaries.

CMS remains diligent in our duties to oversee the quality of care in hospices across the country, and we appreciate the work of the OIG in this area and will continue to work with them as we make improvements to our oversight efforts.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

Expand the deficiency data that accrediting organizations report to CMS and use the data to strengthen its oversight of hospices.

CMS Response

CMS concurs with this recommendation. CMS will work to enhance reporting of the current information about hospice deficiencies that accrediting organizations report to CMS and use it to strengthen oversight of hospices.

OIG Recommendation

Take the steps necessary to seek statutory authority to include information from accrediting organizations on Hospice Compare.

CMS Response

CMS partially concurs with this recommendation. CMS is currently statutorily prohibited from publicly releasing information on any surveys performed by accrediting organizations with the exception of home health agencies and information that relates to a CMS enforcement action.¹ The President's FY2020 Budget includes a proposal to improve safety and quality of care by revising the statute to allow CMS to publicly disclose surveys for all accredited facilities, including hospices. Therefore, we believe that the recommendation to seek statutory authority is complete. If this authority is obtained, we would evaluate the best approach for publicly disclosing these reports, or the most relevant information from these reports, for use by patients and families.

OIG Recommendation

Include on Hospice Compare the survey reports from State Agencies.

CMS Response

CMS does not concur with this recommendation. While CMS is supportive of increased transparency of hospice survey findings, publicly reporting survey reports only from state agencies may be misleading to consumers when researching hospice options. CMS is currently statutorily prohibited from publicly releasing information on any surveys performed by accrediting organizations with the exception of home health agencies and information that relates to a CMS enforcement determination. In FY15, approximately 40 percent of hospice surveys

¹ 42 U.S.C. § 1395bb(b)

were performed by these organizations and could not be publicly disclosed. CMS is exploring ways to increase transparency of hospice quality in a useful, consumer-friendly manner.

OIG Recommendation

Include on Hospice Compare the survey reports from accrediting organizations, once authority is obtained.

CMS Response

CMS partially concurs with this recommendation. If authority is obtained to publicly disclose the accrediting organization survey reports, we would evaluate the best approach for including these reports, or the most relevant information from these reports for consumers on CMS websites, as well as comparable information from state survey agency reports. The process for reporting deficiencies varies between state survey agencies and accrediting organizations, and CMS would need to evaluate how best to disclose this information in a way that would not be misleading to consumers. We would also need to examine available resources and funding to accomplish these actions. We continue to explore ways to increase transparency of hospice quality in a useful, consumer-friendly manner.

OIG Recommendation

Educate hospices about common deficiencies and those that pose particular risks to beneficiaries.

CMS Response

CMS concurs with this recommendation. CMS will continue to educate hospices about common deficiencies through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters as well as through the Integrated Surveyor Training Website. CMS will also educate hospices on the importance of vetting staff, addressing care needs, coordinating care, and maintaining quality controls as they relate to the hospices' conditions of participation.

OIG Recommendation

Increase oversight of hospices with a history of serious deficiencies.

CMS Response

CMS concurs with this recommendation and the need to consider how best to improve oversight of hospices, as we are always looking for ways to improve our programs. Establishing a special focus initiative for hospice presents significant challenges as CMS has limited survey and certification resources. However, CMS already has procedures in place to identify and address hospices with a history of serious deficiencies. During the survey process, surveyors are expected to review previous issues cited as part of their survey to assess current compliance, and cite any deficiencies for correction. Post-survey onsite revisits are conducted as necessary to address serious deficiencies cited. While hospices are surveyed at a 36 month interval, additional surveys may be conducted at any time for complaint investigations. Depending on the severity of deficiencies cited during a survey or investigation, hospices may be terminated if they are unable to come back into compliance within 90 days. We will refer the OIG's list of hospices with a history of serious deficiencies to the appropriate Regional Office and State Survey Agency for review and investigation as necessary based on the information provided.

ACKNOWLEDGMENTS

Jenell Clarke-Whyte served as the team leader for this study. Others in the Office of Evaluation and Inspections who conducted the study include Marissa Baron, Rachel Bryan, and Isabel Platt. Office of Evaluation and Inspections staff who provided support include Joe Chiarenzelli, Althea Hosein, and Berivan Demir Neubert.

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

ABOUT THE OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nation-wide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the healthcare industry concerning the anti-kickback statute and other OIG enforcement authorities.