OIG Urges Increased Regulatory Scrutiny and Expanded Enforcement Options for Hospice

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The U.S. Department of Health and Human Services, Office of Inspector General (OIG) earlier this month issued two companion reports that called for increased regulatory scrutiny of hospices, greater transparency for beneficiaries and their families, and expanded enforcement options to hold poor performing hospices accountable. This article will examine the first report,[1] in which the OIG analyzed deficiency and complaint data from both state agencies and accrediting organizations[2] from 2012 through 2016. The OIG also identified, from the state agency deficiency data, hospices that had at least one serious deficiency or one substantiated severe complaint in 2016. Among the findings in the report:

- During the 5-year analysis period, 4,563 hospices (of 4,799) were surveyed at least once. Eighty-seven percent (87%) of the surveyed hospices were found to have a deficiency at either the standard or condition-level, with 20% having been found to have a serious, condition-level deficiency.
- The percentage of surveyed hospices in each state that had at least one deficiency ranged from 50% in Maine to 100% in Vermont.
- The number of hospices with one or more serious deficiencies increased more than 300% during the analysis period, from 74 in 2012, to 225 in 2016.
- Twenty-eight hospices had at least one immediate jeopardy (IJ) situation, meaning that the non-compliance caused, or is likely to cause, serious injury, harm, impairment, or death.

The top 10 most common deficiencies identified by OIG during the analysis period were:

- Care planning (59%)
  - Providing fewer services than specified in the care plan
  - Failing to ensure that the care plan is appropriately individualized
- Hospice aide services (53%)
  - Failure to supervise aides or provide them with patient-specific care instructions
  - Failure to ensure that aides have the necessary care competencies
- Patient assessments (42%)
  - Patient and family needs were overlooked or inadequately addressed
  - Failure to monitor medication effectiveness or check for side effects during the assessment update process
  - Failure to assess for a patient's history of pain
  - Missed deadlines for completion of required assessments
- Clinical records (37%)
- Organization and administration of services (29%)
- Infection control (29%)
- Core services (26%)

1 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). The second report, "*Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries from Harm*, OEI-02-17-000021 (July, 2019), will be examined in a companion article.

2 Hospices, for a fee, may choose to have their surveys conducted by an accrediting organization rather than by a state agency. Such organizations are approved by the Centers for Medicare and Medicaid Services (CMS). See First Report, at 3.

- Hospice care for hospice-eligible residents of a facility (23%)
- Patient's rights (22%)
- Drugs, biologicals, medical supplies and DME (22%)

The report also addressed serious violations that pose significant risks to patients, including improper vetting of staff for criminal background and history of abuse and neglect, failure to effectively manage pain and treat wounds, and failure to coordinate care with the patients' physicians or with inpatient facilities in which the patients reside.

The OIG examined complaints, noting that one-third of all hospices included in its analysis had complaints filed against them (11 to 14 percent per year), with 32% of the complaints being substantiated. More than 700 hospices had severe complaints filed against them, with 35% being substantiated upon investigation. While the OIG posited that the low rate of substantiation for standard complaints could be due to the fact that some complaints are not required to be investigated until the next onsite survey occurs, which could be months or even years after the complaint, the substantiation rate for severe complaints, which must be investigated by the state agency within two working days in the case of complaints involving IJ situations and 45 calendar days in the case of non-immediate jeopardy high-priority situations, are only slightly higher.

Finally, the OIG identified 313 hospices as "poor performers," having at least one serious deficiency or one substantiated severe complaint in 2016. Of these poor performers, 67% are for-profit whereas 21% are non-profit. The distribution of poor performers roughly reflects the market share distribution of for-profit versus non-profit providers.

In response to its analysis, the OIG made several recommendations to CMS, some of which have been made in previous reports.[3] The OIG's new recommendations urge CMS to:

- Expand the deficiency data that accrediting organizations report to CMS and use these data to strengthen its oversight of hospices and make it more comparable to the data reported by state agencies. Presently, the number of deficiencies for each hospice surveyed is reported differently by accrediting organizations and state agencies. The OIG stated that implementing the recommendation would allow CMS to get a more accurate picture of facility performance and help the agency to better identify hospices with persistent problems. CMS concurred with this recommendation.
- Seek statutory authority to include deficiency data from both state agencies and accrediting organizations on Hospice Compare. Presently, CMS does not include deficiency data on the Hospice Compare website and stated that it is statutorily prohibited from publicly releasing information on surveys conducted by accrediting organizations unless the information relates to an enforcement action. The OIG, however, stated that such information is critical to a consumer's decision when choosing a hospice. CMS partially concurred with this recommendation and 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 such data.
- Include on Hospice Compare the survey reports from state agencies. The OIG noted that CMS is already required to make hospice survey reports from state agencies publicly available, and survey reports for other types of providers, including nursing homes and hospitals, are posted on their respective Compare websites. It, therefore, stated that including them on Hospice Compare would provide transparency and support the delivery of high-quality care for Medicare beneficiaries. CMS did not concur with this recommendation. The agency stated that because it is prohibited from sharing information from surveys by accrediting organizations, sharing information from state agencies would be misleading to the public.
- Include on Hospice Compare the survey reports from accrediting organizations, once authority is obtained. The OIG stated that implementation of this recommendation would provide consumers with in-depth information about quality of care. CMS partially concurred with the recommendation, stating that if statutory authority is obtained, it would evaluate the best approach for including these reports and would examine available resources and funding to inform its decision.

3 See U.S. Department of Health and Human Services, Office of Inspector General, *Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity*: An OIG Portfolio, OEI-02-16-00570 (July, 2018). These recommendations to CMS include analyze claims and deficiency data to inform the survey process, seek statutory authority to establish additional, intermediate remedies for poor performance, and include deficiency data on Hospice Compare.

- Educate hospices about common deficiencies and those that pose particular risks to beneficiaries. CMS concurred with this recommendation and stated that it will include education on the importance of vetting staff, addressing care needs, coordinating care and maintaining quality controls.
- Increase oversight of hospices with a history of serious deficiencies. CMS concurred with this recommendation but noted that establishing a special focus initiative, like that applicable in the nursing home context, presents significant challenges as a result of the agency's limited survey and certification resources.

While it doesn't appear that significant regulatory or enforcement changes are imminent, this report serves to identify specific areas on which providers should focus their compliance efforts. Further, as Medicare hospice expenditures continue to rise, there will be continued calls by the OIG and consumer advocates for increased oversight and an enforcement framework similar to that applicable to nursing homes.

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