



NHPCO Regulatory Alert

Two Reports Released by OIG

To: NHPCO Provider Members
From: NHPCO Regulatory Team
Date: July 9, 2019

Summary at a Glance

On Tuesday, July 9, 2019, the Health and Human Services Office of Inspector General (OIG) released two reports on hospice care, one focused on deficiencies identified in hospice surveys and one focused on a sample of serious harm to hospice beneficiaries and identified vulnerabilities. The OIG's 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.” A summary of both reports is below.

OIG Report #1

[Hospice Deficiencies Pose Risks to Medicare Beneficiaries \(OEI-02-17-00020\)](#)

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, both released today, July 9, 2019. The companion report, [Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries from Harm](#), addresses beneficiary harm in depth.

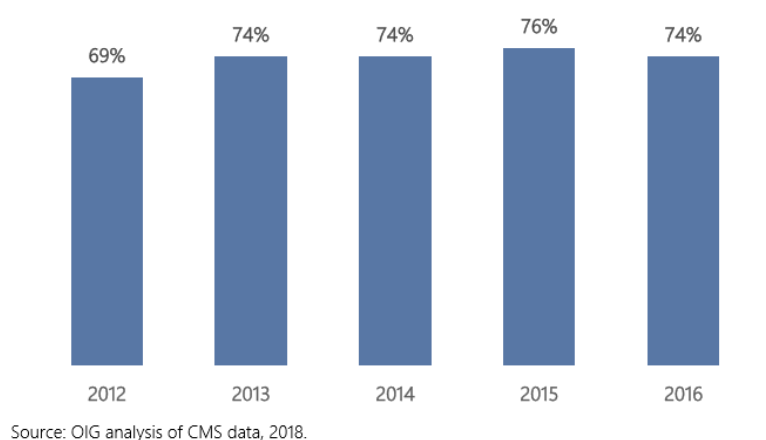
How the OIG did the Report

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

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—but the percentage did decrease slightly in 2016.

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



Immediate jeopardy: 28 hospices had at least 1 Immediate Jeopardy issue 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.

What OIG Found

Hospices are reviewed onsite by surveyors from either State agencies or accrediting organizations. From 2012 through 2016, nearly all hospices that provided care to Medicare beneficiaries were surveyed. Summary data includes:

1. Poor care planning

- a. **Services called for in the care plan were not provided:** 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.
- b. **Care plans not individualized:** 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.

2. Hospice aide training and management

- a. 53% of the hospices surveyed in the 5 years had **deficiencies related to hospice aide and homemaker services**.
- b. 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.
- c. 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.

3. Beneficiary assessment

- a. 42% 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.
- b. **Key content in the comprehensive assessments missed:**
 - i. 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.
 - ii. In some cases, hospices failed to assess the beneficiaries' history of pain.
- c. Hospices also **failed to update assessments within the required timeframe**. Comprehensive assessments must be conducted at least every 15 days, or as frequently as the patient's condition requires. 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.

4. Vetting of staff

- a. 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.
- b. 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.

5. Failure to provide needed services

- a. 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.
- b. Another hospice **did not measure for several weeks a beneficiary's Stage IV 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.

- c. 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.

Summary of Complaint Data

1. **Complaints:** From 2012 through 2016, 1,574 hospices had at least one complaint, and 741 had multiple complaints. One hospice in Florida had a total of 70 complaints in the 5-year period. One hospice in Texas had 12 complaints in 2016 alone. The OIG states that "Numerous complaints against the same hospice raise concerns that it may have systemic problems."
2. **Severe complaints:** In total, 1,143 severe complaints were filed against hospices during the 5-year timeframe, and 35 percent of these complaints were substantiated.
3. **Poor performers:** 313 hospices identified as poor performers, 18% of all hospices surveyed in 2016. Among poor performers, all had at least one serious deficiency or one substantiated severe complaint in 2016. 88% (275 hospices) had a history of other violations, including one other deficiency or substantiated complaint. About half of these hospices had deficiencies or substantiated complaints in multiple years.

OIG Recommendations

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.

The OIG also makes 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.

OIG Report #2

Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries from Harm (OEI-02-17-00021)

The OIG has issued this report featuring 12 cases of harm to beneficiaries receiving hospice care. We examined each case to identify vulnerabilities that could have led to the harm and to determine how such harm could be prevented in the future. Some instances of harm resulted from hospices providing poor care to beneficiaries and some resulted from abuse by caregivers or others and the hospice failing to take action.

The OIG states: “These cases identify areas where there are vulnerabilities in the Centers for Medicare & Medicaid Services efforts to prevent and address harm. These vulnerabilities include:

- insufficient reporting requirements for hospices
- limited reporting requirements for surveyors
- barriers that beneficiaries and caregivers face in making complaints.”

They also report that the hospices featured in this report did not face serious consequences for the harm described in this report. Specifically, surveyors did not always cite immediate jeopardy in cases of significant beneficiary harm and hospices’ plans of correction are not designed to address underlying issues. In addition, CMS cannot impose penalties, other than termination, to hold hospices accountable for harming beneficiaries.

Findings

1. **Poor care provided by the hospice:** including pressure ulcers resulting in gangrene and a leg amputation, maggots around a feeding tube, and prescribed respiratory therapy services not provided by the hospice.
2. **Abuse by caregivers or others where the hospice failed to take action:** including sexual assault, theft of medications by a neighbor, or abuse by a family member not recognized or reported by the hospice.
3. **Barriers to patient/caregiver reporting:** including instances where the hospice mismanaged the family’s grievance over poor pain control for their family member.
4. **State surveyor cannot cite immediate jeopardy when it is warranted:** including providing essential pain medication or addressing patient in pain and vomiting blood for several days.
5. **Hospice plan of correction not designed to address underlying issues.** Plans of correction are generally addressing specific circumstances identified during a survey rather than underlying problems.
6. **CMS cannot impose penalties—other than terminating hospices—to hold hospices accountable for harming beneficiaries.** There are no penalties available to CMS and its surveyors except termination of the Medicare certification, even when beneficiaries are harmed or at significant risk.

Recommendations from the OIG to CMS

1. **Existing recommendation:**

CMS should seek statutory authority to establish additional, intermediate remedies for poor hospice performance. To effectively protect beneficiaries from harm, CMS must have enforcement tools.

2. **New Recommendations to strengthen safeguards to protect Medicare hospice beneficiaries from harm:**

CMS should

- a. strengthen requirements for hospices to report abuse, neglect, and other harm;
 - i. Specifically, CMS should strengthen the hospice Condition of Participation related to the reporting of abuse, neglect, and other harm. The revised CoP should require hospices to report suspected harm—regardless of perpetrator—to CMS, and law enforcement if appropriate, within short timeframes.
- b. ensure that hospices are educating their staff to recognize signs of abuse, neglect, and other harm;
- c. strengthen guidance for surveyors to report crimes to local law enforcement;
- d. monitor surveyors' use of immediate jeopardy citations; and
- e. improve and make user-friendly the process for beneficiaries and caregivers to make complaints.

CMS Response

CMS concurred with the first four new recommendations listed above. For the last recommendation to improve the process for beneficiaries and caregivers to make complaints, CMS partially concurred and stated that it will investigate ways to improve the process “within regulatory constraints and with available resources.”

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NHPCO Public Response

NHPCO issued a public response offering key message points from President and CEO Edo Banach. Find the full public response on the NHPCO website.

Questions

Members with questions should email regulatory@nhpco.org.

1731 King Street • Suite 100 • Alexandria, VA 22314
703/837-1500 • 703/837-1233 (fax) • www.nhpco.org