Mary Myers, MS, RN
Chairman of the Board

HOMECARE & HOSPICE
NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

William A. Dombi, Esq.
President

HOSPICE PERFORMANCE ON HEALTH AND SAFETY SURVEYS – CONCERNS AND CONSIDERATIONS
A NAHC Information Brief

BACKGROUND

The Hospice Benefit: The Medicare Hospice Benefit was created under the Tax Equity and Fiscal Responsibility Act of 1982 and implemented in 1983. This end-of-life care benefit pays hospice programs at prospectively-set per-diem rates (one of four levels depending on the severity of care needs for that day) to arrange, coordinate and manage all care determined to be reasonable and necessary to address the physical, medical, psychosocial, emotional and spiritual needs of a hospice patient's terminal illness and related conditions and to support family members. Patients retain their right to secure services outside of hospice for conditions that are not related to their terminal prognosis.

Initial use of hospice under Medicare was low, but utilization has grown; according to the Medicare Payment Advisory Commission's (MedPAC) **March 2019 Report to Congress**, between 2000 and 2017 the percent of Medicare decedents using hospice rose from approximately 23% to 50.4%. Over that same time frame Medicare hospice spending grew from $2.9 to $17.9 billion and patients served increased from approximately 0.5 million to 1.5 million annually. Due in large part to its comprehensive and compassionate approach to care, hospice patient and caregiver satisfaction rates are high. For fiscal year 2018, the Centers for Medicare & Medicaid Services' (CMS') Quality, Certification and Oversight Reports (QCOR) website reports that there were 4,875 Medicare certified hospices in operation.

Hospice Surveys: The initial hospice statute and regulations included Hospice Conditions of Participation (CoPs) – standards that delineate health and safety requirements that agencies must meet in order to fulfill their Medicare participation agreement – but did not lay out time frames for regularly scheduled compliance surveys. As a result, CMS prioritized surveys for other provider types over hospice. This prioritization and competition for survey and certification resources over the years increased the length of time between routine compliance surveys; it was not uncommon for hospices to go six or more years between surveys, and some went as long as 10 years between surveys.

Surveys are conducted on CMS' behalf by state survey agencies (SAs) and accrediting organizations (AOs). Surveyors assess compliance with the CoPs outlined in Appendix M of the CMS State Operations

Manual. These CoPs primarily cover requirements for patient care and organizational environment of the hospice. Surveyors do not assess compliance with payment requirements.

During 2014, hospice stakeholders worked with Members of Congress to mandate, as part of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act (PL 113-185)), routine compliance surveys with a frequency of at least once every 36 months. The hospice industry supported this change -- so much so that it endorsed use of dedicated funding from within the hospice program to ensure that surveys would take place with dependable frequency. The routine cycle of triennial surveys began during 2015, with roughly 1/3 of all hospices being surveyed each year. As a result, most hospices nationwide are somewhere in the second cycle of routine triennial surveys at this time.

In 2008 CMS completed its most recent overhaul of the Hospice CoPs. Since that time, additional emergency preparedness requirements have been put into effect (beginning in November 2017). The CoPs are comprised of **Conditions**, which are broken down further into various **Standards**. During the survey process a hospice may be cited with various condition-level and/or standard level deficiencies. "'Condition-level" deficiencies are the most serious type of deficiency cited, indicating a provider or supplier is not in compliance with an entire Condition. A "standard level" deficiency means that the provider may be out of compliance with one aspect of the regulations but is considered less serious than a condition-level finding."[i] Hospices that are found to be deficient with one or more conditions or standards must initiate corrective action sufficient to satisfy the survey entity in order to continue in operation. Providers have 90 days to come into full compliance for a condition-level deficiency or risk termination of their Medicare certification. If the condition-level deficiency carries an Immediate Jeopardy (IJ)[ii] finding, the provider has 23 days to come into full compliance. Condition-level deficiencies also typically require a revisit from surveyors to ensure the provider is in full compliance whereas standard-level deficiencies do not require a revisit -- a "desk review" of a provider's plan of correction is typically done by the survey entity for standard level deficiencies.

The number of providers terminated due to condition-level deficiencies is scant. A review of data available to the public indicates there were five or fewer involuntary provider terminations nationally for the current fiscal year and last fiscal year. It is expected that a provider with condition-level deficiencies not able to come into full compliance within 90 days would fall into this involuntary termination category.

If a hospice provider disagrees with a deficiency there is no informal dispute resolution (IDR) process as there is for other providers. Survey entities may allow providers to address disputes, but CMS does not have a process for this, leaving hospice providers without recourse if a surveyor makes a mistake, which has been known to occur. Surveyors frequently survey various other provider types in addition to hospices (i.e. home health agencies, nursing facilities, hospitals, etc.). There have been instances where surveyors incorrectly apply a non-hospice requirement to hospices or apply an incorrect interpretation of hospice requirements. When this occurs, CMS' Central Office has acknowledged it by providing the correct interpretation of the requirement to the Regional Office and/or survey entity, but those hospices cited in the past with the incorrect deficiency do not have an opportunity for their survey record to be

corrected and no public clarification – which could benefit other surveyors and hospice providers – of policy is issued.

Elements for Compliance: Hospices are subject to a broad array of requirements as part of the survey process; as referenced above, these are broken down into **Conditions** and **Standards**. Hospices that do not provide inpatient care directly or serve patients in nursing facilities (NF) or skilled nursing facilities (SNF) are subject to approximately 20 conditions and 80 standards. Additional conditions/standards must be met by hospices that provide inpatient care directly and/or provide services to patients in NFs/ SNFs. Appendix M of the State Operations Manual delineates additional elements beyond the conditions and standards for which hospices are examined for compliance. In total, a hospice that provides inpatient care directly and delivers services in a NF/SNF must comply with more than 300 elements of compliance, while hospices that do not provide inpatient care directly but provide care to residents of SNFs/NFs must comply with more than 260 elements. Hospices not providing inpatient care directly or care to residents of SNFs/NFs must comply with 240 elements. Finally, the Emergency Preparedness requirements that went into effect in November 2017 include three conditions and approximately 40 standards. Given the significant number of items a hospice is scrutinized for, there is a high likelihood that even the most exemplary hospices can be found deficient in at least one element.

OFFICE OF THE INSPECTOR GENERAL (OIG) CONCERNS

Over the years the Department of Health & Human Services OIG has issued numerous reports focusing on various elements of the hospice program. In July 2019 the OIG Office of Evaluations and Inspections issued a two-part series examining the overall quality of care provided to hospice beneficiaries and the deficiencies found by surveyors (Hospice Deficiencies Pose Risks to Medicare Beneficiaries (OEI-02-17-00020)), as well as specific instances of harm and vulnerabilities relative to preventing and addressing potential harm to hospice patients (Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm (OEI-02-17-00021)).

This **Information Brief** is designed to provide a summary of the OIG's findings and some additional contextual insights into the findings presented by the OIG, as well as to present a broad framework for addressing the concerns raised in the reports and as part of industry reactions to the OIG's findings.

Summary of OIG Findings: The OIG examined CMS survey and deficiency complaint data from 2012 through 2016 (the mandatory 36-month survey cycle was implemented in 2015). OIG determined the percentage of hospices that were surveyed for each of these years and the percentage that had at least one deficiency on survey and the percentage of hospices over the five-year period that had at least one deficiency. The OIG also reviewed findings related to hospice complaints. Further, the OIG identified hospices that they classified as "**poor performers**" based on survey and/or complaint findings for 2016. Finally, in the **Safeguards** report, the OIG reviewed survey reports containing 50 known serious deficiencies (hospices with condition-level deficiencies in 2016). From these deficiency reports the OIG profiled some of worst examples of patient harm where there were no ramifications to the hospice

provider. The OIG noted in the report that the "12 cases of harm…do not represent the majority of hospice beneficiaries or the majority of hospice providers."

Following are some key findings from the reports:

Breadth/Level of Hospice Survey Deficiencies: The OIG found that 87% (3,970) of all hospices surveyed over the 2012 through 2016 time period had at least one deficiency (condition or standard-level) during that period. In examining this data on an annual basis, a large proportion of hospices (approximately 74%) were found to have at least one deficiency, although a smaller proportion (20%) were cited for the more serious condition-level deficiencies. The OIG notes that in 2016 the average number of deficiencies (standard and/or condition-level) for hospices surveyed by state SAs was four. To provide some context, data from Nursing Home Compare indicate that the average number of deficiencies per survey for nursing homes (for the 2016, 2017 and 2018 surveys) is around eight; some nursing homes with six deficiencies are still ranked as "much above average" relative to health inspections.

Some of the most commonly cited hospice deficiencies relate to: care planning, provision of hospice aide services, and patient assessments. It is important to note that these three areas contain the highest number of compliance elements a hospice will be subject to (the combined number elements a surveyor will judge the hospice by, including the number of conditions and standards); as a result these areas provide the greatest opportunity for citation.

Complaints against Hospice Providers: When a complaint is received based on allegations of noncompliance and it is believed that the failure to comply, if substantiated, would be considered severe and indicates a substantial performance deficiency, CMS performs a complaint survey to investigate the allegations. If the Regional Office determines it to be appropriate (based on the severity of the allegation), a full survey will be conducted. Over 2012 through 2016, one third of all hospices (1,574) had complaints filed against them; half of those hospices (719) had what would be considered a "severe" complaint filed against them. In each of the years under consideration, the number of hospices subject to complaints was between 11 and 14% of total hospices. The total number of complaints filed during the five years was 3,686, and 32% of those were substantiated (1,190).

About one-half of all hospices with complaints filed over the five-year period (719 of 1,574) were found by the OIG to be subject to a "severe" complaint; about 35% of all severe complaints were substantiated (400).

Hospices with Complaints Filed (2012-2016)*	
Hospices with Complaints Filed	1574
Hospices with Multiple Complaints	741
Hospices with Severe Complaints	719

*on an annual basis, between 11 and 14% of hospices had complaints filed against them

Complaints (2012 – 2016)	Filed	Substantiated
Total complaints	3686	1190
Severe complaints	1143	400

Poor Performers: For 2016 the OIG identified 313 hospices (or 18% of hospices surveyed during that year) as "poor performers"; **Poor Performers** are hospices that had either one serious deficiency or one substantiated severe complaint during the time frame. According to the OIG, a large proportion of these agencies had a history of other violations, including at least one other survey deficiency during the five-year time frame (either condition or standard level); 40 (approximately 12%) of these hospices had other serious deficiencies (condition level) over the five years.

COMMENTARY AND RECOMMENDATIONS

As noted, until 2015 hospices were not surveyed with routine frequency so they received limited feedback on compliance with health and safety standards. Since a hospice is subject to a significant number of conditions and standards during a survey and surveyor judgment can be subjective, it is not expected that all hospices will be found to be 100% compliant during each survey. It should also be noted that deficiencies are primarily focused on process issues, rather than actual outcomes. So a condition-level deficiency (serious) may be a process error with or without patient impact. **However, the OIG's findings have made a valuable contribution to the knowledge base surrounding hospice quality of care.** These include insights into the need for better education regarding commonly cited areas of deficiency as well as improved focus and appropriate corrective action toward providers that perform poorly as evidenced by a history of serious deficiencies and/or substantiated complaints. **The OIG reports have also fostered discussion within the hospice industry around the need to eliminate inconsistencies in the survey process and flawed policy interpretations that create confusion.**

Based on these inputs, the National Association for Home Care & Hospice (NAHC) has identified four key areas for reform related to the hospice survey process. These are outlined below, along with specific actions that should be taken in these areas:

Expand Educational Support and Target Increased Oversight to Foster Hospice Quality of Care	
Increase availability of resources to support continuous quality improvement in hospice care	Require annual publication by CMS of top deficiencies with specific examples of the types of situations that resulted in the deficiencies, as well as CMS' plan of action for addressing these types of deficiencies Make surveyor training available to hospice providers

Enhanced oversight/interventions for high risk providers	Increase survey frequency for deficient hospices and unannounced spot-checks post-deficiency • Time frame for frequency depends on severity of deficiency/frequency of deficiency (for example, in Immediate Jeopardy (IJ) situations or with repeat deficiency providers); provide more frequent follow-up until hospice is deficiency free or free of repeat standard-level deficiencies Institute targeted educational supports from Quality Improvement Organizations (QIOs) to hospice regarding patterns of deficiencies Establish intermediate sanctions for condition-level deficiencies comparable to those applied in home health (temporary management, payment suspension, directed plan of correction, directed in-service training). Civil Money Penalties (CMPs) may be established and imposed as a "second phase" (after other intermediate sanctions have been in place) for use in the following situations: • "Severely egregious" deficiency(ies), (i.e., IJ where harm actually occurred, two or more surveys with IJ or IJ not removed, etc.) • History of condition-level deficiencies • Failed improvement after other alternative sanctions are imposed • CMPs should be reinvested exclusively for hospice-focused activities (similarly to Long Term Care Reinvestment Program)
Additional Patient/Family Support	
	Develop a demonstration for a hospice-focused ombudsman program to: • Address patient advocacy and complaint support • Coordinate with other entities receiving complaints and conducting complaint follow-up
Increasing Transparency	
Improve transparency of survey information/support informed consumer choice	Create a uniform format for recording and reporting of state Survey Agency (SA) and Accrediting Organization (AO) findings Provide full availability of survey reports for both SA and AO surveys (with link from Hospice Compare) once both are available Create summary format for public display of hospice survey findings on Hospice Compare or other appropriate site(s) • Suggestions for "summary" of survey findings include number of deficiencies or identifying hospices with no deficiencies
Improve the Quality and Consistency of the Survey Process	
Address weaknesses in survey process at SA, AO,	Evaluate consistency of the following and initiate corrective action as needed:

and CMS Regional and Federal Levels	• SA surveyor actions (comparison within and between states) • AO surveyor actions pertaining to federal conditions of participation (CoP) • CMS Regional Office interpretations and applications Conduct annual audit of survey accuracy and consistency: • Conduct education of SA and AO surveyors and initiate corrective action where needed • Create/ensure consistent training of all surveyors (SA and AO) and test knowledge in order to be certified or otherwise deemed qualified to conduct surveys • Achieve greater consistency in interpretation and application of CoPs, IJ designation (as well as any intermediate sanctions imposed) Provide SA authority to contract with AOs, if necessary, to ensure all hospice surveys occur timely

[i] Review of Medicare's Program for Oversight of Accrediting Organizations and the Clinical Laboratory Improvement Validation Program Fiscal Year 2018, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-17-AO-CLIA.pdf, page 21.

[ii] Immediate Jeopardy (IJ) represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death. In addition, noncompliance cited at IJ is the most serious deficiency type, and carries the most serious sanctions for providers, suppliers, or laboratories (entities). An immediate jeopardy situation is one that is clearly identifiable due to the severity of its harm or likelihood for serious harm and the immediate need for it to be corrected to avoid further or future serious harm.

For additional information, please contact NAHC Government Affairs at 202-547-7424

Rev. 10/9/2019