

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE HOSPICES:
CERTIFICATION AND
CENTERS FOR
MEDICARE & MEDICAID SERVICES
OVERSIGHT**



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OBJECTIVE

To assess, for Medicare hospices certified by State agencies:

1. the timeliness and results of hospice certification surveys performed by State agencies, and
2. the extent of the Centers for Medicare & Medicaid Services (CMS) oversight of the Medicare hospice program.

BACKGROUND

Medicare Part A covers hospice care provided to terminally ill patients. In recent years, this Medicare benefit has grown in terms of patients served, expenditures, and number of hospices.

Organizations that provide hospice care must be certified by State agencies as meeting minimum participation standards prescribed by CMS. CMS uses Federal comparative surveys and annual performance reviews to evaluate State agencies' survey and certification operations. Certified hospices must undergo recertifications; however, neither law nor regulation specifies the frequency of recertification. Instead, CMS notifies States of the certification frequency for hospices through its annual budget request policy memorandum to the State agencies. For fiscal year (FY) 2005, CMS scheduled hospice certification surveys for every 6 years, but for FY 2006, CMS changed the frequency to every 8 years on average. This change was the result of budget reductions.

Whether 6 years or 8 years, the frequency of hospice certification is far different from the certification frequencies required for nursing homes, hospitals, and home health agencies. While the priority for hospice certification may be lower, CMS did direct State agencies, for FY 2006 surveys, to target 5 percent of the hospices most at risk for having quality problems. Using the results of certification surveys and complaint investigations, CMS has the authority to apply only one enforcement remedy—termination of poorly performing hospices from Medicare.

The report findings are based primarily on analysis of data from CMS's Online Survey Certification and Reporting system. We analyzed these data for 2,537 hospices that were certified by State agencies and were Medicare providers as of July 5, 2005. We also interviewed staff at CMS headquarters and regional offices, State agencies, and professional organizations knowledgeable about hospice issues.

FINDINGS

Eighty-six percent of hospices were certified within 6 years, as required, while 14 percent averaged 3 years past due. Hospices that were 3 years past due for certification had not been surveyed for 9 years—3 years longer than the CMS standard at the time of our review. Two CMS regions accounted for 56 percent of the past-due hospice certifications: Region V (33 percent) and Region IX (23 percent). Only 24 percent of all certified Medicare hospices are located in these two regions.

Applying an 8-year certification frequency to our hospice data decreased the percentage of past-due certifications from 14 percent to 9 percent. However, because the FY 2006 standard is an average rather than a defined interval, it is possible that a State agency could certify some hospices less often than every 8 years and still meet the requirement.

Health deficiencies were cited for 46 percent of hospices surveyed and for 26 percent of hospices investigated for complaints; many deficiencies related to patient care. The most frequent health deficiencies cited during certification surveys and complaint investigations centered on patient care planning and quality. These deficiencies indicated that written care plans either were not prepared or lacked important elements, or that measures to ensure quality patient care were insufficient. Fifteen percent of hospices surveyed between July 2002 and July 2005 received another citation for the same deficiency cited during a previous survey. Of the hospices with deficiencies cited during complaint investigations, 49 percent were also cited for the same deficiencies during certification surveys over the same period.

CMS and State agencies rarely use methods other than certification surveys and complaint investigations to monitor or enforce hospice performance. CMS rarely includes hospices in Federal comparative surveys or annual State performance reviews. Further, both CMS and State agencies infrequently analyze existing hospice performance data. Finally, hospice deficiency data from certification surveys do not include ratings for scope (how many patients are affected) and severity (extent to which patients' safety or health is affected), and individual patient assessment data for hospices are not available. For all these reasons, targeting at-risk hospices, as CMS required for FY 2006, may be difficult for State agencies. CMS has not provided State agencies any direct guidance or specific criteria to identify the at-risk hospices. From July

2002 to July 2005, CMS terminated one hospice from Medicare, and few State agencies exercised their own enforcement measures.

RECOMMENDATIONS

To improve oversight of the Medicare hospice program, we recommend that CMS:

Provide guidance to State agencies and CMS regional offices regarding analysis of existing data and identification of at-risk hospices.

CMS should provide written guidance and/or training that specifies key performance indicators or analysis techniques for hospice data. CMS should also include in its written guidance and/or training how States should identify, using analysis of available data, which hospices are at risk for quality problems. Instituting scope and severity ratings similar to those used for nursing facility deficiency data could provide another method for identifying at-risk hospices. Alternatively, CMS could develop a standard set of indicators for hospice performance, complete data analysis centrally, and ensure that resulting reports are routinely provided to CMS regional office and State agency staffs.

Include hospices in Federal comparative surveys and annual State performance reviews. These surveys and reviews allow CMS to ensure that State agencies meet CMS's performance requirements and to understand overall State agency operations.

Seek regulatory or statutory changes to establish specific requirements for the frequency of hospice certification. Section 1861(dd)(2)(G) of the Social Security Act allows the Secretary to promulgate other regulatory requirements for hospices. CMS should seek a regulatory change that would specify a fixed certification frequency for Medicare hospices with commensurate funding for staffing and implementation. In lieu of a regulatory change, CMS could pursue a statutory change and related funding. Such regulatory or statutory and related budgetary changes could help to ensure that CMS maintains its certification schedules for hospices.

CMS should also seek to increase the frequency of hospice certifications as part of the regulatory or statutory change. The accrediting organizations, the Joint Commission for the Accreditation of Healthcare Organizations and the Community Health Accreditation Program, have set an industry standard of certification every 3 years for hospices. For

CMS, surveys of hospices are the primary method for gaining information about hospice performance in caring for patients.

Seek legislation to establish additional enforcement remedies for poor hospice performance. Currently, CMS's only enforcement remedy against poorly performing hospices is termination of the hospice from the Medicare program. Our results showed that termination is rarely imposed. Less severe remedies could be effective for addressing performance problems that do not merit termination. A potential array of enforcement measures could include directed plans of correction, directed in-service training, denials of payment for new admissions, civil monetary penalties, and imposition of temporary management.

AGENCY COMMENTS

In its comments on the draft report, CMS concurred with the recommendation to provide greater guidance concerning analysis of existing data and identification of at-risk hospices. To this end, CMS reports exploring and implementing methods to become more efficient in targeting its limited resources toward providers most in need of closer oversight. CMS also concurred with the recommendation to include hospices in annual State performance reviews. However, CMS did not concur with greater inclusion of hospices in Federal comparative surveys, citing budget limitations. Additionally, CMS did not concur with the recommendation that it make a regulatory change to establish frequency requirements for hospice certification. CMS stated that, given resource issues, a statutory change, necessitating congressional action, is more appropriate. Finally, CMS is still considering the last recommendation: to pursue new enforcement remedies for poor hospice performance.

OFFICE OF INSPECTOR GENERAL RESPONSE

We continue to recommend that CMS include hospices in the Federal comparative surveys and set a frequency requirement for hospice certification. We acknowledge that this frequency requirement can be set by a statutory change. Consequently, we changed the recommendation that was included in the draft report to include the option of seeking the requirement through either a statutory change or a regulatory change. We look forward to CMS's comments on this final report addressing its consideration of establishing additional enforcement remedies for poor hospice performers.



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OBJECTIVE

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2. the extent of the Centers for Medicare & Medicaid Services (CMS) oversight of the Medicare hospice program.

BACKGROUND

Medicare Hospice Benefit

The Tax Equity and Fiscal Responsibility Act of 1982¹ established the Medicare hospice benefit for eligible beneficiaries under Medicare Part A.^{2,3} As defined by CMS, hospice care focuses on relief of pain and uncomfortable symptoms for terminally ill patients, rather than curative care or life-prolonging treatment.^{4,5} Medicare hospice services include nursing care, counseling, and home health aide services, as well as drugs and medical supplies. Hospice care is provided either by freestanding hospices or by hospices owned or operated by home health agencies, hospitals, and skilled nursing facilities. In the late 1980s, nearly all patients enrolled in hospice care had a primary diagnosis of cancer,⁶ but by 2004, more than half of hospice enrollment was for other terminal illnesses, such as end-stage heart disease or dementia.⁷

Hospice Utilization and Cost

In recent years, the Medicare hospice benefit has grown in terms of patients served, number of hospices, and expenditures. From 2001 to 2004, the number of patients using Medicare hospice services increased nearly 34 percent (from 605,239 beneficiaries to 809,431 beneficiaries),⁸ while overall enrollment in Medicare rose 4.25 percent.⁹ As of July 5, 2005, according to CMS data, 2,774 hospices were certified for Medicare,¹⁰ an increase of approximately 11 percent since 2003. Expenditures for the Medicare hospice benefit have risen from \$3.5 billion in 2001 to \$8.6 billion in 2005, a 145-percent increase.^{11, 12} In 2005, expenditures for Medicare hospice services accounted for 4.8 percent of total Part A expenditures.¹³

Hospice Participation In Medicare

Medicare regulations set minimum standards, called conditions of participation, with which hospices must comply to participate in the Medicare hospice program.¹⁴ On May 27, 2005, CMS published a

proposed rule modifying the current conditions of participation for Medicare hospices; the comment period ended July 26, 2005.¹⁵ As of October 2006, CMS had completed its evaluation of all comments received.¹⁶

CMS approves hospices for Medicare participation after receiving results of hospice surveys from one of two entities—a State agency or a recognized accreditation organization.¹⁷ These surveys assess the extent to which hospices meet the conditions of participation. As of July 2005, State agencies had certified 92 percent of Medicare hospices.¹⁸ State surveyors had reviewed each of these hospices and had indicated to CMS that the hospices' certification results met the minimum requirements for Medicare participation. For the same period, the remaining 8 percent of Medicare hospices had undergone accreditation surveys deemed by CMS to meet or exceed the standards of the Medicare conditions of participation. The accreditation organizations recognized by CMS for this purpose are the Community Health Accreditation Program (CHAP) and the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO).

Hospice Certification Surveys by State Agencies

State agencies, under contract to CMS, conduct onsite certification surveys to determine whether hospices meet Medicare health, safety, and program standards. They conduct surveys for: (1) an initial certification, (2) a recertification, (3) a followup or revisit after an earlier survey has cited deficiencies, and (4) an investigation of complaints. During all surveys, State surveyors must cite deficiencies when hospices fail to meet conditions of participation or other CMS program standards.

CMS guidelines on certification frequency. Neither law nor regulation specifies the frequency of Medicare certification surveys for hospices. In contrast, nursing facility certification is required by statute at least every 15 months, with a 12-month average.¹⁹ Home health agency certifications are due at least every 36 months.²⁰ Accreditation organizations survey hospices every 3 years.

CMS establishes the frequency and priority of hospice certification as part of its budget process for State agency survey and certification activities. The CMS fiscal year (FY) 2005 Budget Call Letter, which provided survey instructions to the State agencies, required certification surveys of Medicare hospices at least every 6 years.²¹ This 6-year standard has been in effect since FY 2000. The FY 2005 Budget Call

Letter also ranked survey and certification activities in a four-tier priority system. Tier I, the highest priority, encompassed activities required by statute and thus did not include hospices. CMS required State agencies to complete all Tier I activities before completing those in Tiers II through IV, but planning for all survey and certification activities in a fiscal year was ongoing. Complaint investigations for all provider types, including hospices, fell under Tier II. Hospice certifications, with a few exceptions, appeared in Tier III. (See Appendix B for a more detailed explanation of FY 2005 survey and certification priorities.)

In August 2005, CMS released its FY 2006 Mission & Priority Document,²² which, like the FY 2005 Budget Call Letter, provided survey instructions to the State agencies. For FY 2006, hospice certifications were still a Tier III priority; however, the frequency of hospice certification changed from every 6 years to every 8 years on average. CMS attributed this change in survey frequency specifically to “reductions from the President’s 2005 proposed budget which affected the base for 2006.”²³ CMS also noted in this document that part of this reduction had targeted the survey and certification functions. CMS added a new Tier II requirement for a 5-percent targeted survey of State-identified hospices most at risk for quality problems. CMS did not specify how State agencies are to identify at-risk hospices. Finally, under Tier IV, States are encouraged to conduct additional surveys and bring the average down to 6 years, if resources permit. (See Appendix C for a more detailed explanation of FY 2006 survey and certification priorities.)

Complaint investigations. Complaints against certified hospices to the State agencies by various parties, e.g., ombudsmen, patients, or patients’ families, trigger an investigation process which often begins with an onsite visit. Surveyors determine whether they can substantiate allegations and may identify other deficiencies during the investigations. State surveyors, at their discretion, may expand the investigations into full certification surveys. As noted, complaint investigations fall into Tier II and thus have higher priority than hospice certification, found in Tier III.

CMS Oversight Activities

CMS is responsible for imposing remedies or sanctions on noncompliant hospices and for conducting Federal monitoring surveys.

Enforcement for noncompliance. State surveyors cite deficiencies against hospices that are not compliant with the Medicare conditions of participation. If they are not corrected in a timely manner, some cited deficiencies may be severe enough to warrant enforcement actions by CMS or State agencies. Deficiencies cited against hospices, unlike those against nursing facilities, have no ratings for scope (how many patients are affected) or severity (extent to which patients' safety or health is affected). Termination from the Medicare program is the only enforcement action that CMS can initiate against noncompliant hospices.²⁴ In contrast, CMS may impose civil monetary penalties or denial of Medicare payments as well as terminations on nursing facilities. State agencies may also initiate their own enforcement actions against hospices based on survey results.

Federal monitoring surveys. CMS monitors State agencies' Medicare certification processes through two Federal monitoring surveys—comparative surveys and annual performance reviews. CMS uses comparative surveys to assess State surveyor performance through a Federal resurvey, conducted within 60 days of a State certification survey of any Medicare provider subject to these surveys, which includes hospices. CMS also conducts annual performance reviews of State agencies to evaluate survey and certification operations overall.

CMS Oversight Data

As part of its oversight responsibility, CMS collects national and State survey data, including data for Medicare hospices certified by the State agencies, which it maintains in its Quality Improvement & Evaluation System (QIES). One component of QIES is the Online Survey Certification and Reporting system (OSCAR), from which CMS can extract national and State data. OSCAR contains provider performance data collected from State certification surveys. It also maintains information about Federal monitoring surveys and enforcement actions. State agencies enter provider, survey, and complaint information into CMS's Automated Survey Processing Environment (ASPEN), which is uploaded to the OSCAR system.²⁵

METHODOLOGY

We based the report findings primarily on analysis of OSCAR data for all hospices that were certified for Medicare by State agencies and were active hospice providers as of July 5, 2005. Our analysis did not include the 8 percent of hospices with JCAHO or CHAP accreditation that CMS had deemed as meeting Medicare standards. To assess the extent to which State agencies met CMS requirements for frequency of hospice certification, we applied CMS's criteria for FY 2005 (certification every 6 years) and FY 2006 (certification every 8 years on average). We analyzed health-related deficiencies cited against hospices by State agencies, but we did not include life-safety code deficiencies. Interviews with CMS staff and surveys of State agencies and accreditation organizations provided additional information on oversight activities from State, national, and provider perspectives. (See Appendix A for a detailed methodology.)

Hospice Study Population

Of the 2,774 hospices in the OSCAR database, we identified 2,537 that were certified for Medicare by State agencies and that were active Medicare providers as of July 5, 2005. We eliminated 220 accredited hospices that CMS had deemed as meeting Medicare standards and 17 hospices that had received no Medicare hospice payments in CY 2004.²⁶

Data Collection and Analysis

We determined from the OSCAR data the frequency and results of hospice certification surveys, results of complaint investigation surveys, completion of Federal monitoring surveys, and enforcement actions taken. Data on Medicare payments to the State-certified hospices from 1998 to 2004 came from the Healthcare Information System (HCIS). We conducted followup with the five States that had the greatest number of hospices past due for certification or the longest past-due certifications. We surveyed all State agencies to obtain information about their actions and priorities regarding hospices. Finally, we interviewed key staff from CMS headquarters and regional offices and from professional associations concerning oversight of Medicare hospices.

Certification frequency. Using OSCAR data, we calculated the frequency of certification surveys and the number of Medicare hospices for which State agencies met the 6-year standard for certification. We used two timeframes:

Prior Survey ◀-----▶ Last Survey ◀-----▶ July 5, 2005

1. *Date of last certification survey to July 5, 2005.* For each State-certified hospice, we calculated the elapsed time between its last certification survey and July 5, 2005. This identified hospices for which the last certification surveys were (a) 6 years old or less or (b) more than 6 years old.
2. *Date of prior certification survey to date of the last certification survey.* For each hospice in group (a) above, we calculated the elapsed time between the prior certification survey and the last certification survey. We then compared the elapsed times to the 6-year standard. This analysis does not include hospices that were certified as new providers during their last surveys.

Based on the results for timeframe 1, we contacted five States that had the greatest number of hospices with (1) past-due certifications and (2) certifications more than 6 years past due; i.e., the last certification was 12 or more years ago. Three States (California, Illinois, and Michigan) met both criteria. We then selected the next State remaining on each list (Minnesota and Maryland). For these States, we verified whether they had reported all survey activities and we inquired about what circumstances, if any, contributed to the past due certifications we had identified. Finally, for the timeframe encompassing the date of each hospice's last certification survey to July 5, 2005, we calculated how many hospices in our study population had been certified within 8 years.

Survey results, Federal monitoring, and enforcement. We analyzed 3 years of OSCAR data (July 5, 2002, through July 5, 2005) for information about certification deficiencies for 1,394 hospices surveyed in that period. We also examined the same OSCAR hospice data for all 981 complaint investigations conducted and for Federal monitoring surveys and enforcement actions, if any.

From these data, we determined the number of hospices cited for health-related deficiencies and the types and frequencies of these deficiencies. Our analysis did not include deficiencies cited for life-safety codes, which address building, fire, and environmental codes. We also determined the number of complaint investigation surveys for hospices, frequency of deficiencies cited, and survey outcomes.

I N T R O D U C T I O N

From the information on Federal monitoring surveys, we identified the extent to which the surveys included hospices. We also counted how many terminations for enforcement purposes were either initiated or completed against hospices. Through interviews, we addressed CMS's annual State agency performance reviews with respect to hospices. Lastly, discussions with CMS and a survey of all State agencies provided qualitative data on workload priorities and enforcement tasks.

CMS monitoring and oversight. We conducted structured interviews with staff from CMS headquarters and regional offices to obtain information on the current hospice issues affecting oversight and on the extent to which CMS uses survey data to monitor hospice performance. We also interviewed staff at professional hospice associations and accreditation organizations—namely, the National Hospice and Palliative Care Organization (NHPCO), the National Association for Home Care and Hospice, CHAP, and JCAHO—for their perspectives of CMS's monitoring and oversight activities.

Standards

This study was conducted in accordance with the “Quality Standards for Inspections” issued by the President’s Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

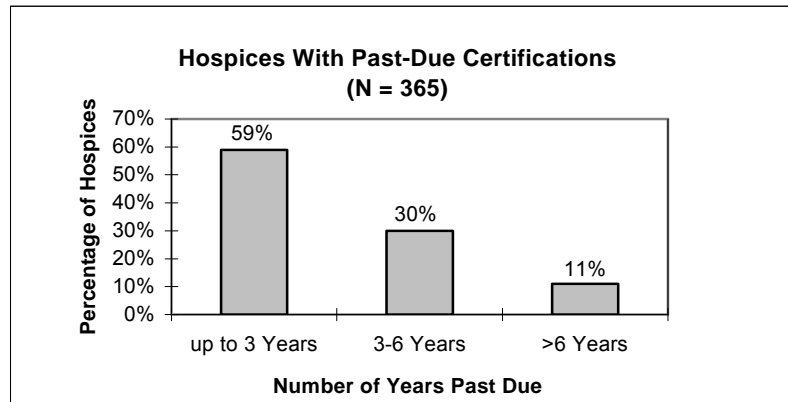
Eighty-six percent of hospices were certified within 6 years, as required, while 14 percent averaged 3 years past due

For the period of our review, the CMS standard required hospice certification every 6 years. Eighty-six percent of

hospices (2,172 of 2,537) had been certified within the 6 years ending July 5, 2005. The remaining 14 percent of hospices (365) were past due for certification because the last certification for each had occurred more than 6 years before July 5, 2005.

On average, hospices past due for certification had not been surveyed for 9 years—3 years longer than the CMS standard

The extent to which the 365 hospices were past due for certification ranged from 34 days to more than 13 years, averaging 3 years past due. Eleven percent of these hospices were more than 6 years past due, with their last certification surveys having occurred more than 12 years before July 5, 2005 (see chart below). Medicare payment data from 1998 to 2004 show that all hospices with past-due certifications received Medicare payments for each of these years. In 2004 (the last full calendar year of payment data available), Medicare payments to each hospice with a past-due certification averaged \$2.7 million.



Source: Office of Inspector General (OIG) analysis of elapsed time between last survey and July 5, 2005, CMS OSCAR data.

Two CMS regions accounted for 56 percent of hospices with past-due certifications: Region V (33 percent) and Region IX (23 percent). Only 24 percent of all certified Medicare hospices are located in these two regions. Three States account for 41 percent of all hospices with past-due certifications: Michigan (12 percent) and Illinois (12 percent) in Region V, and California (17 percent) in Region IX.

To verify our findings regarding past-due certifications, we contacted State agency staff in five States (California, Illinois, Michigan, Minnesota, and Maryland) that had the most hospices with past-due certifications or the most past due by 6 or more years. Staff from these States reported that their workload priorities based on required State and Federal activities contributed to the delays we identified, as did resource constraints, such as insufficient or untrained staff to conduct surveys.²⁷

Of hospices with timely certifications in their last cycles, 33 percent had been certified late in their prior cycles

Of the hospices that were certified within 6 years as of July 2005, 70 percent (1,515 of 2,172) had earlier certifications also subject to the 6-year standard. Thus, we were able to calculate for these 1,515 hospices the elapsed time between their prior certification surveys and their last certification surveys. For 33 percent of these hospices, the elapsed time was more than the required 6 years.²⁸

Changing the certification frequency to every 8 years on average will likely improve the compliance rate, but some hospices may still be certified less often than every 8 years

In the FY 2006 Mission & Priority Document of August 2005, CMS notified State agencies of revised hospice survey and certification requirements for FY 2006. According to this document, CMS made changes to FY 2005 certification frequency for some providers due to reductions in the President's 2005 proposed budget. To address this reduction, one change decreased the FY 2005 hospice certification frequency from every 6 years to every 8 years on average per State with a new Tier 4 expectation that additional surveys be conducted to bring the 8-year average up to a 6-year average.

To determine the effect of the FY 2006 requirement, we applied an 8-year certification frequency to our hospice data but did not calculate an overall average for certification frequency. This reduced the proportion of past-due certifications from 14 percent under the FY 2005 requirement to 9 percent under the FY 2006 requirement. However, because the FY 2006 standard is an average rather than a defined interval, it is possible that a State agency could certify some hospices less often than every 8 years and still meet the requirement.

Certifying hospices no more often than every 6 years was a concern expressed by staffs from two professional associations knowledgeable about hospice issues, NHPCO and JCAHO. During interviews, each

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association's staff indicated that the priority and frequency of hospice certification should be consistent with the priority and timeframes required for other facilities providing care for seriously ill patients, i.e., hospitals, nursing facilities, and home health agencies. Some State agency and CMS regional office staff expressed similar concerns but attributed the change to the budget reductions and the lack of legislative or regulatory requirements. However, State agency staffs indicated that they generally schedule work for all providers based on the higher priority levels of statutory and regulatory requirements reflected in the CMS budget letter instructions.

Health deficiencies were cited for 46 percent of hospices surveyed and for 26 percent of hospices investigated for complaints; many deficiencies related to patient care

From July 2002 to July 2005, State agencies conducted 1,815 certification surveys for 1,394 Medicare hospices. Of these hospices, 46 percent (642 of 1,394) were cited for at least one

health deficiency, and 15 percent (213 of 1,394) received repeat citations for the same deficiencies cited during previous surveys.²⁹ Some hospices had multiple survey visits, presumably to follow up on prior deficiencies.

In the same timeframe, State agencies conducted 981 complaint investigations for 577 hospices. Of these hospices, State agencies cited health deficiencies for 26 percent (152 of 577). Further, of the 152 hospices with deficiencies, 49 percent (75 of 152) were also cited for the same deficiencies during certification surveys over the same period. Thirty-eight percent (222 of 577) of the hospices were the subjects of two or more complaint investigations conducted during the review period.

The most frequently cited health deficiencies on certification surveys related to care planning and quality issues

The 13 most frequently cited health deficiencies accounted for 43 percent of deficiencies cited against the 642 hospices.³⁰ Twelve of these 13 deficiencies related to care planning and quality issues. (See Table 1 on the next page.)

Thirty percent of deficiencies were cited for problems with hospices' care planning for their patients. These cited deficiencies show that a written care plan either was not completed for each patient or lacked important elements of acceptable care planning. Another 11 percent of the health deficiencies cited indicated that efforts to ensure quality patient care were also insufficient. Proper care planning and ensuring that needed

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care is provided are important for establishing an acceptable level of quality for patient-specific care.

Table 1: Most Frequent Health Deficiencies From Certification Surveys		
Deficiencies (cited if the element is missing or insufficient)	Percentage of Deficiencies (N=3,534)	Hospices Cited*
Plan of Care		
L-133 written plan of care established, maintained for each individual	6%	202
L-135 plan reviewed, updated at intervals specified in plan	5%	176
L-137 plan states scope, frequency of services needed	5%	172
L-136 plan includes assessment of needs, identification of services	4%	148
L-134 establishment of plan of care	3%	100
L-200 plan of care for bereavement services reflects family needs	3%	100
L-155 periodic review and update of each individual's plan of care	2%	82
L-211 written instructions for patient care are prepared by RN for aides	2%	74
Ensuring Quality Patient Care		
L-176 maintains clinical record for every individual receiving care/services	3%	116
L-210 RN visits home site at least every 2 weeks when aide services provided	3%	115
L-209 services available/adequate in frequency to meet needs of patients	3%	96
L-142 conduct self-assessment of quality, appropriateness of care provided	2%	81
Administrative		
L-108 governing body assumes legal responsibility for hospice's total operation	2%	84
Total	43%	
*Number of hospices cited does not total 642 because hospices may be cited for more than one deficiency.		

Source: OIG analysis of OSCAR database for 3-year period ending July 5, 2005.

The most frequently cited deficiencies during complaint investigations also related to care planning and quality

Complaint investigations substantiated 43 percent (423 of 981) of the complaints, meaning that those complaint allegations were found to be valid. This resulted in State agencies' citing health deficiencies for 37 percent (360 of 981) of complaint investigations against 152 hospices.

The 12 most frequently cited deficiencies resulting from complaint investigations accounted for 42 percent of the deficiencies cited.³¹ (See Table 2 on the next page.) Eleven of these 12 deficiencies pertained to problems with patient care planning and quality, the same deficiencies cited during certification surveys. Twenty percent of the cited deficiencies show that a written plan was either not prepared for each patient or lacked important elements. Another 19 percent of health deficiencies indicated a quality of care problem, almost always in connection with ensuring that patients received adequate and appropriate care. Because OSCAR records did not indicate the nature of the actual complaints, we could not determine whether the cited

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deficiencies were directly related to the complaints or were discovered during the complaint investigation.

Table 2: Most Frequent Health Deficiencies From Complaint Surveys		
Deficiency (cited if the element is missing or insufficient)	Percentage of Deficiencies (N=1,347)	Hospices Cited*
Plan of Care		
L-133 written plan of care established, maintained for each individual	7%	75
L-136 plan includes assessment of needs, identification of services	6%	64
L-135 plan reviewed, updated at intervals specified in plan	4%	53
L-137 plan states scope, frequency of services needed	3%	33
Ensuring Quality Patient Care		
L-194 services provided in accordance w/ recognized standards of practice	3%	43
L-176 maintains clinical record for every individual receiving care/services	3%	37
L-103 assures continuity of patient/family care in all settings	3%	37
L-192 services directed or staffed to assure needs	3%	35
L-116 make nursing and physician services, drugs available on 24-hour basis	3%	34
L-185 patient's clinical records must contain complete documentation of all services/events, including evaluations, treatments, progress notes, etc.	2%	31
L-209 home health aide and homemaker services must be available and adequate in frequency to meet patient's needs; aide must meet other specified requirements	2%	25
Administrative		
L-108 governing body assumes legal responsibility for hospice's total operation	3%	36
Total	42%	
*Number of hospices cited does not total 152 because hospices may be cited for more than one deficiency.		

Source: OIG analysis of OSCAR database for 3-year period ending July 5, 2005.

CMS and State agencies rarely use methods other than certification surveys and complaint investigations to monitor hospice performance and enforce standards

According to CMS and State agency staffs, onsite surveys for certification and complaint investigations are their primary methods for determining whether hospice providers meet Federal program standards.

In addition to conducting certification and complaint investigation surveys, CMS and State agencies have other options for oversight of the Medicare hospice program. CMS can monitor State agencies' certification processes (and performance of some hospices) by conducting Federal comparative surveys and annual State performance reviews. Both CMS and State agencies can also analyze available, but limited, certification and complaint investigation data to review hospice performance. CMS's only enforcement remedy for poor performance by

hospices is termination of these providers from the Medicare program; State agencies may have additional enforcement measures.

CMS rarely includes hospices in Federal comparative surveys or annual State performance reviews

CMS performs comparative surveys to review the accuracy of State agency surveys. The comparative survey is an onsite Federal resurvey of a provider, which could include a hospice, within 60 days of the State agency survey. From July 2002 to July 2005, CMS conducted comparative surveys for 13 of 2,537 hospices, about one-half percent of the certified hospices in our population. We verified these data on comparative surveys with all 10 CMS regional offices. Staff from 6 of the 10 regional offices reported that they had conducted comparative surveys for some provider type in the same 3-year period; 4 reported that they had not conducted any comparative surveys in that period. Staff from two of the six regional offices indicated that they had sometimes included at least one hospice, and staff from four acknowledged that they rarely or never included hospices.

Staff in 5 of 10 CMS regional offices reported conducting performance reviews of State agencies and their survey operations from 2002 to 2005. All five staffs indicated that they rarely focused these reviews on survey operations for hospices. Their stated reasons were that hospices account for lower Medicare expenditures than other provider types and that they serve fewer beneficiaries relative to other Medicare programs. They also noted that hospices lack statutory or regulatory requirements that, if present, would make hospices a higher priority for CMS and State agencies.

CMS and State agencies infrequently analyze existing hospice performance data; both face several challenges in identifying at-risk hospices as required for FY 2006

The CMS FY 2006 Mission & Priority Document requires a new certification survey for a 5-percent sample of at-risk hospices per State (Tier II). CMS requires State agencies to use “their judgment” to identify and target those hospices “most at risk of quality problems.”³² CMS has not provided State agencies any direct guidance or specific criteria for identifying these hospices.

Staff from 8 of the 10 CMS regional offices reported that they rarely analyze available OSCAR and ASPEN hospice data to identify potential problems for specific hospices or to identify trends among hospices or States. Staff from one regional office reported that for 3 years they had

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requested training from CMS headquarters regarding how to analyze the available hospice data but had received none. Of the 41 State agencies responding to our survey, 19 reported that they do not define poorly performing hospices; 22 define poor performance but not based on analysis of available data.

Two months after the release of the FY 2006 Mission & Priority Document in August 2005, we asked all State agency staffs how they would prioritize their hospice workloads. Of the 42 responding State agencies, 34 answered that they would consider the date of the last survey, but none specifically reported that they would target those hospices for which the last survey was more than 6 years ago. Eighteen State agencies indicated that in FY 2006, they had targeted or would target hospices based on complaint investigations and on the seriousness of any cited deficiencies. Scheduling of survey workloads for FY 2006 also included consideration of hospices with new complaints that warranted investigation (Tier II) and of certification surveys of hospices seeking to become new Medicare providers (Tier III).

CMS and State agencies face several data limitations in identifying at-risk hospices. Unlike data for nursing facilities, hospice deficiency data do not include ratings for scope (how many patients are affected) and severity (extent to which patients' safety or health is affected). In addition, CMS and State agencies have no individual patient outcome and assessment data from hospice providers by which to monitor quality of care. At present, hospices are not required to report individual patient assessment data similar to those reported to the Minimum Data Set for nursing facility residents or maintained on home health agencies and their patients in the Outcome and Assessment Information Set (OASIS). CMS's proposed changes to the conditions of participation for hospices include capturing individual patient data.³³ CMS states that hospices could voluntarily provide the data to an existing private system, e.g., NHPCO. In interviews, CMS staff indicated an interest in collecting such patient information but that it is not currently considering the establishment of such a data repository.

From July 2002 to July 2005, CMS terminated one hospice from Medicare; few States exercised their own enforcement measures

Currently, CMS's only enforcement remedy for noncompliant hospices is termination from Medicare based on recommendations by the State agencies. In the 3 years from July 2002 to July 2005, one hospice was terminated as a result of severe problems identified during an initial survey. In that same period, 93 hospices voluntarily left the Medicare program—71 of them because of mergers with other hospice providers and 22 for a variety of other reasons.

Of the 42 State agencies responding to our survey, 32 reported having their own enforcement measures. These include such remedies as focused in-service training, civil monetary penalties, plans of correction, and loss of State licensure which would result in termination from the Medicare program.³⁴ However, only 8 of these 32 State agencies had invoked any enforcement action against a hospice from July 2002 to July 2005. State agencies' staffs attributed their limited focus on hospices, and thus their infrequent use of available enforcement measures, to relatively small Medicare expenditures and low beneficiary enrollment. Like the CMS regional office staffs, they also noted that hospices lack the statutory or regulatory requirements to make them a higher priority.



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CMS is responsible for the oversight of certified Medicare hospices and their terminally ill patients. CMS's primary sources of information about hospice performance are the results of State agencies' certification surveys, complaint investigations, and recommendations for termination when warranted. Neither statute nor regulation specifies survey frequency for hospices, but from FY 2000 to FY 2005, CMS policy set the frequency at every 6 years. For FY 2006, because of budgetary constraints, CMS changed its policy on survey frequency to every 8 years on average. CMS policy has consistently assigned a higher priority to certification surveys of hospitals, nursing homes, and home health agencies than it has to certification surveys of hospices.

Our analysis of OSCAR data through July 2005 found that State agency certifications for 86 percent of hospices met the CMS standard, while 14 percent of hospices were past due by 3 years on average. Changing the certification frequency to every 8 years on average will likely improve the compliance rate. However, because this is an average, a State agency could certify some hospices less often than every 8 years and still meet the requirement. Our analysis also showed that State agencies cited a substantial proportion of hospices for health-related deficiencies during certification surveys and complaint investigations.

CMS's oversight activities rarely included hospices in its Federal comparative surveys or annual State performance reviews, nor did CMS staff report analyzing existing hospice performance data. Also for FY 2006, CMS required State agencies to annually target a 5-percent sample of at-risk hospices for certification. However, CMS has not provided State agencies guidance for identifying at-risk hospices, and specific performance data on hospices are limited.

Based on our findings, we conclude that CMS needs to strengthen its oversight of the Medicare hospice program to better protect both the program and its beneficiaries. Specifically, we recommend that CMS:

Provide Guidance to State Agencies and CMS Regional Offices Regarding Analysis of Existing Data and Identification of At-Risk Hospices

Analysis of existing data. CMS should provide written guidance and/or training that specifies key performance indicators or analysis techniques for hospice data. CMS regional office and State agency staffs reported that they rarely analyze available OSCAR and ASPEN data for

hospice performance. Alternatively, CMS could develop a standard set of indicators for hospice performance, complete data analysis centrally, and ensure that the resulting reports are routinely provided to CMS regional offices and State agency staffs.

Analysis of these existing certification, deficiency, and complaint investigation data would enable CMS and State agencies to identify potential problems at specific hospices or to identify trends among hospices or States. For example, our analysis showed that 15 percent of hospices surveyed between July 2002 and July 2005 received a repeat citation for the same deficiency cited during previous surveys. It also identified hospices which were cited during both certification surveys and complaint investigations in the same 3-year period.

Identification of at-risk hospices. CMS should provide written guidance and/or training on how State agencies should analyze available data to identify which hospices are at risk for quality problems. For FY 2006, CMS has required a 5-percent targeted survey of at-risk hospices as a priority activity. However, CMS has not provided State agencies any direct guidance or specific criteria for identifying these hospices so that State agencies can include them in their planned workloads.

For better identification of at-risk hospices, CMS could also institute ratings of scope (how many patients are affected) and severity (extent to which patients' safety or health is affected) for cited hospice deficiencies. These ratings are not currently available for hospices in the OSCAR database. CMS and State agencies also have no individual patient outcome and assessment data from hospice providers with which to monitor quality of care. Our analysis of OSCAR data identified that health deficiencies cited for hospices frequently pertained to patient care planning and quality. To add this more-specific information, CMS could modify existing survey and certification databases to include hospice scope and severity ratings similar to those used for nursing facility deficiency data. Linking scope and severity ratings to the specific health deficiencies cited for a hospice would better inform a decision to terminate a hospice from the Medicare program.

Include Hospices in Federal Comparative Surveys and Annual State Performance Reviews

CMS's Federal comparative surveys and annual State performance reviews rarely include hospices. These surveys and reviews allow CMS to ensure that States agencies meet CMS's performance requirements and to understand overall State agency operations. These surveys also

provide CMS the opportunity to review the State survey processes used by the surveyors and to identify inconsistent methods that may require additional training or clarification, such as appropriately identifying, citing, and reporting deficiencies.

Seek Regulatory or Statutory Changes To Establish Specific Requirements for the Frequency of Hospice Certification

At present, neither law nor regulation specifies the frequency of Medicare certification surveys conducted by State agencies for hospices. However, Section 1861(dd)(2)(G) of the Social Security Act, which applies specifically to hospices, allows the Secretary to promulgate other regulatory requirements. These other requirements could include frequency of hospice certifications. In lieu of a regulatory change, CMS could pursue a statutory change.

CMS should seek a regulatory or statutory change, with commensurate funding, that would specify a fixed certification frequency for Medicare hospices. Such a change would enable CMS to maintain its certification schedules for hospices despite general budget cuts. CMS has noted in its FY 2006 Mission & Priority Document that budgetary constraints caused it to change its policy on survey frequency from every 6 years to every 8 years on average. However, a regulatory or statutory change would allow the Secretary to designate a portion of the overall departmental budget for hospice survey and certification.

As part of the change, CMS should also seek to increase the frequency of hospice certifications. Surveys every 3 years is the industry standard for hospices, as practiced by the accrediting organizations, JCAHO and CHAP. Nursing facilities and home health agencies, which also care for seriously ill patients, are certified at least every 15 months and every 3 years, respectively. For CMS, surveys of hospices are the primary method for gaining information about hospice performance in caring for patients. Staff from two professional associations knowledgeable in hospice issues supported more frequent hospice certifications.

Seek Legislation To Establish Additional Enforcement Remedies for Poor Hospice Performance

Currently, CMS's only enforcement remedy against poorly performing hospices is termination from the Medicare program. Our review found that termination is rarely imposed. The cited deficiencies that we reviewed, when taken together, identify potentially serious problems in care planning and quality. In some cases, termination may be the appropriate remedy. However, less severe remedies could be effective

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for addressing performance problems that do not merit termination. A potential array of enforcement measures could include directed plans of correction, directed in-service training, denials of payment for new admissions or all patients, civil monetary penalties, and imposition of temporary management.

AGENCY COMMENTS

In its comments on the draft report, CMS stated that its management challenge is to make the most effective use of whatever resources are appropriated. To this end, CMS reports diligently exploring and implementing methods to become more efficient in targeting those resources toward providers most in need of closer oversight. For hospices, examples include targeted surveys of at least 5 percent of sample hospices identified by the State as being most “at risk,” inclusion of hospices in State Performance Standards, the addition of contract surveyors to assist CMS in performing oversight surveys, the development of hospice reports to assist States in targeting at-risk hospices, and plans to publish new Conditions of Participation for hospices in 2008 that set expectations for hospice accountability.

CMS concurred with our first recommendation to provide greater guidance concerning analysis of existing data and identification of at-risk hospices. Its planned guidance involves alerting States and CMS’s regional offices to the availability and usefulness of a number of reports that can help to identify the at-risk hospices. However, CMS has indicated that given the very limited number of administrative enforcement actions available to it, adding scope and severity indicators for cited hospice deficiencies would add little to no value.

CMS concurred partially with our second recommendation. While agreeing to include hospices in annual State performance reviews, which it began in FY 2006, CMS did not concur with greater inclusion of hospices in Federal comparative surveys, citing budget limitations.

CMS did not concur with our third recommendation to make a regulatory change to establish frequency requirements for hospice certification. CMS considers this a statutory issue necessitating congressional action to address fundamental resource issues.

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Finally, CMS neither concurred nor nonconcurred with our fourth recommendation to pursue new enforcement remedies for poor hospice performance. CMS is continuing to consider the recommendation.

For the full text of CMS's comments, see Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

We recognize that since this evaluation concluded, CMS has taken a number of steps to improve its oversight of hospices by developing new tools and enhancing available processes. However, we continue to recommend several additional actions.

Responding to our first recommendation, CMS states that given the very limited number of administrative enforcement actions available to it, scope and severity indicators would add little to no value to the hospice reports available through its data systems. However, without a scope and severity component associated with deficiencies or complaints, there appear to be few ways to identify the pervasiveness and seriousness of cited problems within hospices. Scope and severity ratings are currently utilized for both nursing homes and home health agencies. Further, given that termination is the only available enforcement remedy, scope and severity ratings would provide additional assessment information to more effectively determine whether to terminate a hospice from the Medicare program or to identify it as an at-risk hospice.

We continue to recommend that CMS include hospices in the Federal comparative surveys. These surveys provide CMS with the opportunity to ensure State performance, understand overall State agency operations, and review and ensure consistency of State survey processes.

We continue to recommend that CMS set a frequency requirement for hospice certification. We acknowledge that this frequency requirement can be set by a statutory change. CMS has the authority to set a frequency for hospice certification surveys through regulation; however, we acknowledge that a statutory change could also address this issue. Consequently, we changed the third recommendation in the draft report to add the option of seeking statutory change to establish a specific frequency requirement. Either vehicle could be used to address this recommendation.

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With respect to our final recommendation, we look forward to CMS's comments to this final report addressing its consideration of establishing additional enforcement remedies for poor hospice performers.

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- ¹ Public Law 97-248 § 122, 96 Stat. 324, 356 established the Medicare hospice benefit for eligible Medicare Part A beneficiaries.
 - ² Section 1861(u) of the Social Security Act (the Act) created hospices as a provider category, and Section 1861(dd)(1) defines the scope of benefits for hospice care and the hospice program.
 - ³ 42 CFR § 418 sets forth the Conditions of Participation. Specifically, 42 CFR § 418.50(b)(2) states that hospices must provide care “that is reasonable and necessary for the palliation and management of terminal illness and related care. . . .”
 - ⁴ Medicare Hospice Benefits pamphlet, CMS, July 2005.
 - ⁵ Section 1861(dd)(1) of the Act.
 - ⁶ “Medicare Program Expenditures Associated With Hospice Use,” LRP-200402-07, RAND Corporation, 2004.
 - ⁷ RAND Corporation, February 2004, and National Hospice and Palliative Care Organization. Available online at http://rand.org/research_areas/health/ and <http://www.nhpco.org/templates/1/homepage.cfm>. Accessed September 2005 and March 2006, respectively.
 - ⁸ “CMS’s Health Care Information System (HCIS), 1998–2004.” Available online at <http://www.cms.hhs.gov/FilesForOrderGenInfo/>. Accessed August 2, 2005.
 - ⁹ Overall enrollment increased from 40,025,724 beneficiaries in 2001 to 41,728,804 beneficiaries in 2004. “Medicare Enrollment: National Trends 1966 to 2005.” Available online at <http://www.cms.hhs.gov/MedicareEnRpts/Downloads/HISMI05.pdf>. Accessed July 2005.
 - ¹⁰ As of July 5, 2005, according to OSCAR data, there were actually 2,757 hospices receiving Medicare reimbursement; 17 hospices were not active Medicare providers.

- 11 “Data Book: Healthcare Spending and the Medicare Program,” Chapter 6, MedPac, June 2004.
- 12 2005 CMS Statistics. Available online at <http://www.cms.hhs.gov/home/rsds.asp>. Accessed July 2006.
- 13 “2005 CMS Statistics,” CMS Pub. No. 03455, Table 30, September 2005.
- 14 42 CFR § 418 sets forth the Conditions of Participation. 42 CFR § 488.100 requires an additional condition applicable only to hospices that provide short-term inpatient care and respite care directly, rather than under arrangements with other participating providers.
- 15 Medicare and Medicaid Programs: Hospice Conditions of Participation, Federal Register, Vol. 70, No. 102, May 27, 2005, Proposed Rule, pp. 30840–30893.
- 16 Telephone interview with Senior Nurse Consultant, Office of Clinical Standards and Quality, CMS, on October 26, 2006.
- 17 Section 1864(a) of the Act establishes the relationship between CMS and State agencies relating to Medicare certification processes.
- 18 CMS OSCAR data extracted July 5, 2005.
- 19 Sections 1819(g)(2)(A)(iii) and 1919(g)(2)(A)(iii) of the Act and 42 CFR § 488.308 require that each skilled nursing facility and nursing facility receive a certification survey no later than 15 months after the last day of the previous certification survey. Further, the statewide average interval between certification surveys of skilled nursing facilities and nursing facilities cannot exceed 12 months.
- 20 Section 1891(c)(2)(A) of the Act states that certification surveys will occur no later than every 36 months with more frequent surveys within this interval permitted.

- ²¹ “FY 2005 State Survey and Certification Budget Call Letter,” CMS memorandum to Directors, State Survey and Certification, June 10, 2004.
- ²² “Quality Assurance for the Medicare & Medicaid Program, FY 2006 Mission & Priority Document, Survey and Certification,” CMS, August 5, 2005.
- ²³ “Quality Assurance for the Medicare & Medicaid Program, FY 2006 Mission & Priority Document, Survey and Certification” (Managing Resource Limitations), p. 9.
- ²⁴ 42 CFR § 488 (Survey, Certification, and Enforcement Procedures) and 42 CFR § 489 (Provider Agreements and Supplier Approval).
- ²⁵ CMS plans to replace OSCAR with the Certification and Survey Provider Enforcement Reporting (CASPER) system. CASPER will be an end-product database for reporting collected QIES information. No date is available for this change.
- ²⁶ For these 17 hospices, the CMS HCIS database showed no Medicare hospice payments in 2004, the last full calendar year of payment data available at the time of our study.
- ²⁷ CMS requires that surveyors attend its course, Basic Hospice, before conducting certification surveys for hospices. According to a few State agencies’ staffs at the time of our surveys in Summer 2005, CMS last offered this course more than 3 years ago. However, CMS staff said the agency offered the training in August 2005 and January 2006.
- ²⁸ For 25 hospices, their last surveys occurred in 1999 when the certification frequency was every 10 years. When we allowed 10 years in elapsed time between the prior survey and the last survey for these 25 hospices, none of the last certifications were completed late. These 25 hospices are not included in the 33-percent statistic.
- ²⁹ We excluded 1 percent of the OSCAR records from the deficiency frequency analysis because these records indicated that a health

deficiency was cited; however, the specific deficiency tag was not reported.

- ³⁰ The table reflects the most frequently cited deficiencies from *certification surveys* that represented 2 percent or more (before rounding) of all deficiencies cited in the 3-year period ending July 5, 2005.
- ³¹ The table reflects the most frequently cited deficiencies from *complaint investigations* that represented 2 percent or more (before rounding) of all deficiencies cited in the 3-year period ending July 5, 2005. Another 10 deficiencies, not identified in the table, represented less than 2 percent before rounding (1.63 percent to 1.93 percent) and accounted for an additional 18 percent of cited complaint deficiencies. Nine of these ten deficiencies were for patient care planning or quality.
- ³² “Quality Assurance for the Medicare & Medicaid Program, FY 2006 Mission & Priority Document, Survey and Certification,” CMS, August 5, 2005.
- ³³ Medicare and Medicaid Programs: Hospice Conditions of Participation, Federal Register, Vol. 70, No. 102, Proposed Rule, pp. 30840–30893, May 27, 2005.
- ³⁴ Interviews with CMS regional office staff concerning CMS oversight identified possible State enforcement actions beyond CMS terminations.

Inspection Methodology

Data Sources

Report findings apply to hospices for which certification resulted from State agency surveys. Survey and certification data found within the Centers for Medicare & Medicaid Services' (CMS) Online Survey Certification and Reporting (OSCAR) and Medicare payment data from the Healthcare Information System (HCIS) database were primary data sources for analysis. Additional sources were consulted to identify deemed hospices as well as to better understand the oversight environment from State, national, and provider perspectives.

Specific information from OSCAR used in this evaluation and available as of July 5, 2005, includes:

- hospice provider data;
- survey and certification data, including deficiencies cited for the 3-year period July 5, 2002, through July 5, 2005;
- complaint survey data, including deficiencies cited, for the 3-year period July 5, 2002, through July 5, 2005; and
- Federal monitoring survey data for the 3-year period July 5, 2002, through July 5, 2005.

We also utilized the following information:

- hospice payment data from CMS's HCIS for years 1998 through 2004;
- inquiry results from several State agencies in States with extreme cases of certified hospices past due for certification;
- reports submitted by accreditation organizations to CMS for quarters 1 and 2 of 2005;
- accreditation activity data for hospices deemed as meeting Medicare requirements obtained directly from the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO);
- structured discussions regarding CMS's management of hospices with key personnel from CMS central and regional offices, JCAHO, the Community Health Accreditation Program (CHAP), the National Hospice and Palliative Care Organization (NHPCO), and the National Association for Home Care and Hospice (NAHC);

- results of a national survey of State agencies about hospice oversight and enforcement; and
- recent survey and certification budget letters and workload guidance sent by CMS to State agencies.

Evaluation Population

As of July 5, 2005, the OSCAR system showed that 2,774 hospices certified for Medicare by State agencies were active providers. Proper identification of hospices deemed as meeting their certification requirements through an accreditation survey was necessary to exclude them from analysis for this report. However, the number of deemed hospices in OSCAR was significantly lower than the number reported to us by CMS and the accreditation organizations. As a result, we also relied on hospice data supplied by accreditation organizations to CMS and to the Office of Inspector General directly.

CMS requires accreditation organizations to report activities related to deemed hospices on a quarterly basis. Although this is done electronically, the OSCAR system is not typically updated with this information. We requested copies of quarterly reports from CMS and requested data directly from both accreditation organizations. Quarterly reports were available only for recent quarters and only JCAHO fulfilled our request. However, this information proved valuable for identifying all hospices deemed by JCAHO rather than simply those deemed within the last 3 months. Quarterly reports submitted by CHAP were more historical, containing all deemed hospices in addition to those recently accredited and deemed. Based upon our review, we identified 220 deemed hospices that were active at the time of the evaluation. Preliminary analysis of survey frequency was conducted on the remaining 2,554 hospices certified by State surveys.

Measures of Certification Frequency

To determine certification frequencies, we measured the elapsed time between the last survey date identified in OSCAR and July 5, 2005, for all active hospices certified by State surveys. We verified with CMS that, for each year from fiscal year (FY) 2000 to FY 2005, it had instructed State agencies to certify Medicare hospices every 6 years. For FYs 1998 and 1999, the frequency of certification was set at every 10 years.

Hospices whose last certification surveys were less than 6 years old as of July 5, 2005, were considered to be current. Among hospices

considered current on certification, not enough time had elapsed for a certification survey to become due. Hospices whose last surveys were more than 6 years before July 5, 2005, were initially considered to have past-due certifications. However, we allowed a grace period of 31 additional days, and only certifications that remained past due after that adjustment were determined as past due for analysis purposes. Thus, for hospices reported as having past-due certifications, more than 6 years and 1 month had elapsed between their last survey and July 5, 2005.

For hospices having both current certifications and prior certification survey dates, we measured the elapsed time between the prior surveys and the last surveys. Here, too, we allowed a grace period of 31 days. When the elapsed time between prior and last surveys exceeded 6 years and 1 month, hospices were classified as having late certification surveys. We made one exception to this measurement. For 25 hospices, their most recent surveys occurred in 1999, when the certification standard was every 10 years. Therefore, when we allowed 10 years in elapsed time between the prior surveys and the last surveys for these 25 hospices, we found that none of them was late for its last certification. Approximately one-third of hospices having current certification surveys did not have prior survey dates. They were relatively new providers and their last surveys were conducted for initial certification.

Inactive Hospices

Initial results, which showed that some hospices were past due on their certifications by up to 13 years, suggested that these hospices might not be active Medicare providers. We matched hospices shown as active providers in OSCAR with HCIS payment data from 1998 through 2004 to verify that they had received Medicare payments. This data match showed that 17 hospices had no Medicare payments for 2004 or prior years. Searches of the NHPCO and NAHC hospice provider databases failed to find 8 of the 17 hospices in either database. The remaining nine hospices were in the NHPCO or NAHC databases, but not both. Ultimately, we learned that of the remaining nine hospices, three had invalid phone numbers, five had discontinued hospice services, and one had merged with another hospice.

We concluded that all 17 hospices were inactive providers and should have been removed from the OSCAR system. We excluded them from our evaluation population, leaving a total of 2,537 State-surveyed

hospices for analysis. This served as the final population used for analysis of survey frequencies, survey deficiencies, complaint surveys, complaint survey deficiencies, Federal monitoring surveys, and enforcement actions.

Hospices Selected for Followup

Of the States with the greatest number of past-due certification surveys and/or the most time elapsed since surveys were due, we selected a few for additional followup. We identified the top five States in terms of two aspects of late certification surveys: (1) those with the greatest number of late certification surveys and (2) those with the greatest number of late certification surveys more than 6 years past the date for which the certification surveys should have occurred. Three States (California, Illinois, and Michigan) met both qualifications. We then selected the next State remaining on each list (Minnesota and Maryland). We asked these five State agencies to provide explanations as to why so much time had elapsed since the last surveys were conducted for the five hospices most past due.

Interviews

In addition to analyzing survey frequency and results, we conducted structured interviews with key personnel of CMS headquarters; 10 CMS regional offices; and the accreditation organizations with deeming authority for hospices, CHAP and JCAHO. These discussions provided context for understanding current issues affecting management activities, the extent to which survey data are used to monitor hospice performance, vulnerabilities in oversight activities, and available enforcement actions. We spoke with staff of NHPCO and NAHC about CMS management activities from the hospice provider perspective.

State Agency Survey

We conducted an e-mail survey of State agencies about oversight and enforcement activities related to hospices within their States. Of the 51 agencies surveyed (including Puerto Rico), 42 responded to our questionnaire.

CMS Program Guidance

As stated previously, most criteria for hospice certification and review are found in programmatic guides, rather than statute or regulation. The 6-year hospice certification standard used in this evaluation was outlined in the FY 2005 State Survey and Certification Budget Call Letter. We found that the same standard had been applied annually since FY 2000. Budget call letters are sent annually by CMS to State agencies. They direct how survey and certification workloads for all provider types should be prioritized for the year. Provider types are prioritized using a four-tier system. Tier I is given top priority, followed by Tiers II through IV. For FY 2005, State agencies were expected to prioritize their work using that system. Hospices were placed in Tier III, except for complaint investigations. Complaint investigations were classified as Tier II activities, regardless of the provider type being investigated.

During this evaluation, CMS released new guidelines for the next fiscal year. On August 5, 2005, CMS issued the “Quality Assurance for the Medicare & Medicaid Program, Fiscal Year 2006 Mission & Priority Document, Survey and Certification.” Though renamed, it serves the same purpose as previous budget call letters. The FY 2006 Mission & Priority Document relaxed frequency guidelines for certifications of hospices and other non-long-term-care providers. Non-long-term-care provider certifications are still a Tier III activity, but the requirement that they occur at least every 6 years was replaced with a target of an 8-year average. Under Tier IV, States are encouraged to conduct additional surveys and bring the average down to 6 years, if resources permit.

**Fiscal Year 2005 Selected Centers for Medicare & Medicaid Services
Priority Survey Activities for Selected Providers**

PROVIDER OR ACTIVITY	Tier I	Tier II	Tier III	Tier IV
Core Infrastructure	Specific administrative and systems activities are identified under each tier. Activities in each tier must be completed before activities of the subsequent tiers are begun. Examples of activities within each tier include timely entry of survey workload data, maintenance of all systems and hotlines, performance measurement activities, training, etc.			
Complaint Investigations		Complaint investigations of all provider types		
New Provider Initial Surveys			Initial certification surveys of all provider types	
Nursing Facility	Certification surveys, frequency requirements per nursing home	<ul style="list-style-type: none"> – Nursing Home Oversight and Improvement Program expectations delineated by the Centers for Medicare & Medicaid Services (CMS) and through various memorandums requiring States to intensify their review of facilities' abilities to prevent bedsores, dehydration, malnutrition – Fund additional costs associated with immediate sanctions – Fund additional costs associated with special focus initiatives and conducting surveys on repeat offenders with serious violations – Fund costs associated with staggering timing of nursing home inspections 		
Home Health Agency	Recertification surveys within 3 years		5% validation surveys of deemed home health agencies	
Hospital Accredited	1% sampled validation surveys identified by CMS			
Hospital Nonaccredited		<ul style="list-style-type: none"> – 33% recertification covers all levels of facilities – 5% prospective payment system-excluded hospitals, rehabilitation units, and psychiatric units no later than 90 days after cost reporting period 		
Hospice*			<ul style="list-style-type: none"> – Recertification surveys every 6 years – 5% validation surveys of deemed hospices 	
*The identified survey priority activities for hospices are the same as those for ambulatory surgical centers, outpatient physical therapy providers, comprehensive outpatient rehabilitation facilities, portable x-ray providers, and rural health clinics. Only the required hospice validation survey is not required of these.				

Source: CMS's fiscal year 2005 State Survey and Certification Budget Call Letter to State agency directors and regional CMS administrators. Shaded areas indicate no suggested priority activity for that tier.

**Fiscal Year 2006 Changes to Selected Centers for Medicare & Medicaid Services
Priority Survey Activities for Selected Providers**

PROVIDER OR ACTIVITY	Tier I	Tier II	Tier III	Tier IV
Core Infrastructure	Changed from listing under tiers in FY 2005 to a standard core requirement, all of which must be completed			
Complaint Investigations	Unchanged from FY 2005			
New Provider Initial Surveys			Initial certification surveys of all provider types	
Nursing Facility	Unchanged from FY 2005			
Home Health Agency	<ul style="list-style-type: none"> – 36-month maximum interval for certification surveys – Extended surveys required when complaint investigations identify substantiated noncompliance 	<ul style="list-style-type: none"> – 5% additional targeted sample survey identified by the Centers for Medicare & Medicaid Services (CMS) as most at risk of poor care; may count toward 36-month interval – 5% validation surveys of deemed home health agencies identified by CMS 		24-month average for additional surveys based on State judgment for agencies most at risk for poor care to ensure that all agencies are surveyed on average every 24 months (to ensure 50% agencies surveyed each year on average)
Hospital Accredited	<ul style="list-style-type: none"> – 1% sampled validation surveys of accredited hospitals identified by CMS – 1% targeted additional stratified random sample surveys – Full certification surveys for each complaint investigation resulting in substantiated noncompliance 	5% validation surveys of deemed Critical Access Hospitals identified by CMS		
Hospital Nonaccredited		<ul style="list-style-type: none"> – 6-year maximum interval between certification surveys – 5% targeted sample survey identified by Centers for Medicare & Medicaid Services (CMS) as most at risk of providing poor care 	<ul style="list-style-type: none"> – 4.5-year average for additional recertification surveys based on State determination of most at risk of quality problems (at least 22% per year) – Inpatient prospective payment system surveys (new and 5% existing) 	<ul style="list-style-type: none"> – 3-year average based on additional recertification surveys based on State determination of most at risk of poor care – Recertification surveys of all new critical access hospitals within 12 months of initial survey (both to ensure 33% of hospitals are surveyed annually)

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**Fiscal Year 2006 Changes to Selected Centers for Medicare & Medicaid Services
Priority Survey Activities for Selected Providers**

PROVIDER OR ACTIVITY	Tier I	Tier II	Tier III	Tier IV
Hospice*		5% targeted sample surveys based on State judgment of most at risk of quality problems that may count toward the State average 8-year survey interval in Tier III	– 8-year average for additional recertification surveys based on State determination of most at risk quality problems – 5% validation surveys of deemed hospices identified by CMS	6-year average for additional recertification surveys (to ensure that all hospices in State are surveyed no less than every 6 years)
*The identified survey priority activities for hospices are the same as those for ambulatory surgical centers, outpatient physical therapy providers, comprehensive outpatient rehabilitation facilities, portable x-ray providers, and rural health clinics. Only the required hospice validation survey is not required of these.				

Source: CMS's FY 2006 Survey Frequency & Priority chart in the FY 2006 Mission & Priority Document for Survey and Certification. Other provider types omitted for purposes of this report include psychiatric hospitals, end stage renal disease facilities, ambulatory surgical centers, outpatient physical therapy providers, comprehensive outpatient rehabilitation facilities, portable x-ray providers, and rural health clinics. Shaded areas indicate no suggested priority activity for that tier.

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 22 2007

TO: Daniel R. Levinson
Inspector General

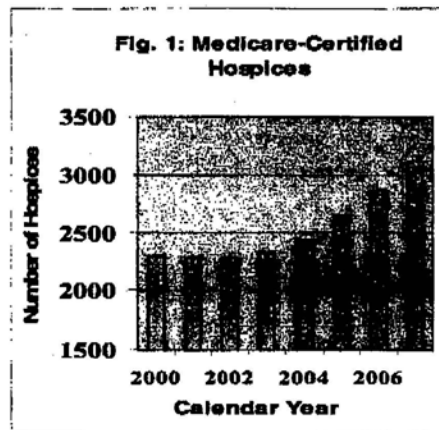
FROM: Leslie Norwalk, Esq.
Acting Administrator

SUBJECT: OIG Draft Report: "Medicare Hospice: Certification and Centers for Medicare and Medicaid Services Oversight" (OEI-06-05-00260)

Thank you for the opportunity to review and comment on the above-referenced report from the Office of Inspector General (OIG). The Centers for Medicare & Medicaid Services (CMS) appreciates the contributions and valuable input by the OIG in reviewing the certification and oversight of Medicare hospices. The purpose of this report was to assess, for Medicare hospices certified by State Survey Agencies (SAs)—(1) the timeliness and results of hospice certification surveys performed by SAs, and (2) the extent of the CMS oversight of the Medicare hospice program.

In examining the timeliness of hospice surveys, it is important to distinguish between budget issues and management issues. By now, the budget issues related to Medicare survey and certification funding are increasingly well-known. For example, the fiscal year (FY) 2007 appropriation level for survey and certification is \$25 million below the President's budget request. Since 2003 there has been only one year in which the Survey and Certification (S&C) budget was increased.

Meanwhile, the number of providers in Medicare has increased significantly. For example, the following graph portrays the 34 percent growth in the number of hospice programs nationally from 2000 to 2007.

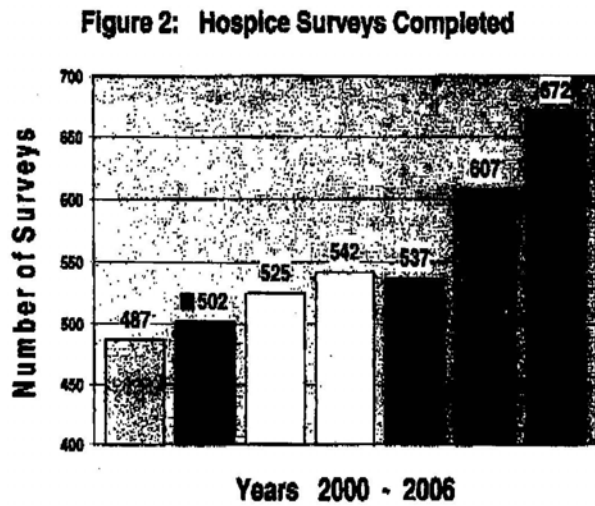


The extent to which the number of surveys can be increased to match the growth in the number of providers is primarily a function of the budget, as determined by the Congress.

The CMS' **management challenge** is to make the most effective use of whatever resources are appropriated. Given considerable growth in the number of providers at the same time that resources measured in real dollars have declined, we have assiduously explored and implemented methods to become more efficient in targeting scarce resources toward those providers most in need of closer oversight. Examples include:

Targeted Surveys: We raised the priority of hospice surveys by directing States to survey at least a 5 percent sample of hospices identified by the State as being most at risk of quality problems. Such targeted surveys are now at the second highest priority level (compared to the third-highest priority level for most other non-long-term care surveys). The addition of hospice in the State Performance Standards System (SPSS) (see below), together with the new higher priority for hospices compared to the past (and compared to certain other competing demands), largely accounts for the fact that the number of surveys of hospices has increased in recent years.

Figure 2 shows the increase from 487 surveys in year 2000 to 672 in year 2006. The 38 percent increase in the number of surveys thereby enabled the percentage of providers who are surveyed to remain relatively constant despite the 34 percent increase in the number of providers participating in Medicare. As a result, approximately 20.6 percent of hospices were surveyed in FY 2000, while 21.9 percent were surveyed in FY 2006.



Inclusion of Hospice in State Performance Standards: Beginning FY 2006 we added hospice surveys to the SPSS. SAs are rated on whether they met the required frequency for hospice surveys. If the timeframe for completing hospice surveys is not met, the SA fails the performance measure and must submit a corrective action plan which the regional office (RO) monitors.

Hospice Data Reports: To assist States in targeting surveys to providers most at risk of quality deficiencies, we implemented a system of electronic reports which provide States

with instant and convenient access to key S&C information. This system, "Providing Data Quickly" (PDQ), reports data in three categories: provider reports, survey reports, and deficiency reports. The reports may be customized to provide data at the CMS RO level, to the State level, and the individual provider level.

Validation Surveys: We awarded a contract at the end of FY 2006 and are currently working with the contractor to develop the survey process and recruit surveyors. The contract surveyors will perform oversight surveys in order to help CMS monitor SA performance.

Quality Assurance Standards: The CMS plans to publish new Conditions of Participation (CoPs) for hospice in 2008. The new CoPs will establish a framework for Quality Assessment and Performance Improvement. CMS will amend the hospice section of the State Operations Manual (SOM) to reflect clear expectations for hospice accountability. The guidance in the SOM will enable hospice surveyors to make accurate decisions regarding compliance with Medicare regulations.

Responses to Specific OIG Recommendations:

OIG Recommendation

Provide guidance to the State agencies and the CMS regional offices regarding analysis of existing data and identification of at-risk hospices.

CMS Response

We concur. Seven hospice reports were developed and established in the CMS' PDQ to support the oversight efforts of the ROs and SAs. The availability of the reports as well as the content of the reports have been discussed in the last three bi-monthly RO calls. CMS will ensure that the ROs and SAs receive written instructions that reinforce the availability of the reports and their purposes.

Complaints received on hospices are entered into the ASPEN Complaints/Incidents Tracking System (ACTS) by the States. ACTS produces a variety of reports that may be used for analysis and evaluation of hospice provider performance. The review of these complaints/reports will assist in the targeting of at-risk hospices. CMS will ensure that the ROs and SAs are using and analyzing the data reports in ACTS as part of their oversight, monitoring, and pre-survey process.

Traditionally, we have used scope and severity (e.g., in the context of nursing homes) for selecting the appropriate enforcement response. However, in the hospice arena there are a very limited number of administrative enforcement actions available, so scope and severity would add little to no value.

CMS Action

1(a): We will send a survey and certification policy letter to all ROs and SAs advising them of the availability of the hospice PDQ reports.

1(b): Information on hospice trends and the analysis of hospice data will be presented to SA directors at the Annual Leadership Summit in April 2007.

1(c): The availability and the use of the hospice PDQ reports will be discussed at regularly scheduled calls with CMS ROs. The ROs will also share this information with their SAs.

OIG Recommendation

Include hospices in Federal comparative surveys and annual state performance reviews.

CMS Response

We concur. We already added hospices to the SPSS for frequency of surveys (beginning in FY 2006). The SAs are now assessed on whether they meet the timeframes required by CMS for hospice surveys. This information was conveyed in the FYs 2006 and 2007 Mission & Priority Document, as well as various meetings.

However, greater inclusion of hospices in the CMS validation surveys (otherwise known as "comparative" or "look-behind" surveys) must await additional resources. The validation surveys are performed either by CMS ROs or by a national contractor. Obviously, any expansion to the CMS validation surveys to include hospices would exacerbate the demands on the survey and certification budget as previously mentioned.

CMS Action

2(a): Hospice surveys have been and will continue to be included in the SPSS.

2(b): Increased Federal validation surveys will be conducted when additional resources are available.

2(c): Follow up will be made with States not meeting the required frequency for hospice surveys through the RO Follow-Up System.

OIG Recommendation

Seek regulatory changes to establish specific requirements for the frequency of hospice certification.

CMS Response

We disagree with this recommendation. We believe that this issue should not be addressed in regulation and is primarily a statutory issue for consideration by the Congress.

The dominant constraint on survey frequency is the budget and the lack of any mechanism to adjust S&C certification funding to match increases in the number of providers. The only statutory change that would effectively address this situation would be one that automatically correlated the expected frequency and number of surveys with the resources to accomplish the mission. Simply mandating a frequency for hospice surveys, without addressing the fundamental resource issues, would only reduce the surveys for another provider type (e.g., for ambulatory surgical centers) without a deliberative process to determine that hospices merited greater attention compared to other types of providers.

OIG Recommendation

Seek legislation to establish additional enforcement remedies for poor hospice performance.

CMS Response

We will consider this recommendation further. In the meantime, we will continue to improve our oversight of hospices by employing the tools and initiatives we have discussed above.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Kevin K. Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office.

Leah K. Bostick served as the team leader for this study. Scott Whitaker from the Office of Evaluation and Inspections Dallas regional office contributed to this report. Central office staff who contributed to this report include Tricia Davis, Sandy Khoury, and Barbara Tedesco.