OIG Details Hospice Quality of Care Issues and Recommends Tougher Enforcement Measures

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Earlier this month, the U.S. Department of Health and Human Services' Office of Inspector General (OIG) issued two companion reports that, together, called for increased regulatory scrutiny of hospices, greater transparency for beneficiaries and their families, and expanded enforcement options to hold poor performing hospices accountable. A summary and analysis of the first report, *Hospice Deficiencies Pose Risks to Medicare Beneficiaries*[1] is available here. In the second report, *Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries from Harm*[2] (the "Second Report"), OIG sought to identify vulnerabilities in the efforts of the Centers for Medicare and Medicaid Services (CMS) to prevent and address harm to hospice patients occasioned by poor care, abuse, and other problems. OIG used 12 actual cases from a sample of 50 condition-level deficiencies in 2016 to illustrate its findings. OIG stated that it selected the 12 cases because of the severity of harm to the patients involved, but noted that the 12 cases do not represent the majority of hospice patients or providers. OIG further stated that it did not independently verify the accuracy of the information included in the survey reports underlying the cases it selected for inclusion in the Second Report.

Among OIG's findings in the Second Report:

- *Some instances of harm resulted from hospices providing poor care to hospice patients.*
  - A hospice patient developed pressure sores after starting hospice care. The sores worsened to the point that the patient developed gangrene, ultimately necessitating amputation of a portion of one leg.
  - A hospice patient developed maggots around his feeding tube insertion site and had to be transferred to a hospital.
  - Despite calling for respiratory therapy in the patient's care plan, a hospice did not provide any respiratory therapy for over two months.
- *Some instances of harm resulted from abuse by caregivers or others and the failure of the hospice to take action.*
  - A hospice providing services to an assisted living resident failed to recognize signs of possible sexual assault on the resident's body.
  - A hospice patient's son, who served as his father's primary caregiver, would allow his father to fall and refuse to pick him up. Despite a report by a social worker who identified caregiver burnout as a concern with respect to the son, the hospice failed to intervene, change the patient's care plan or provide for inpatient respite care.
  - A hospice patient's daughter kept her mother restrained in bed so that she wouldn't get up. In addition, she also would leave her mother restrained in a wheelchair in the bathroom and spray her with water when she called out for help. The daughter also refused changes to her mother's drug regimen because she preferred to have her mother sedated. The hospice's social worker made a visit to the home several weeks after being notified of signs of abuse and failed to assess the mother's safety during the visit.

1 U.S. Department of Health and Human Services, Office of Inspector General, *Hospice Deficiencies Post Risks to Medicare Beneficiaries*, OEI-02-17-00020 (July, 2019).

2 U.S. Department of Health and Human Services, Office of Inspector General, *Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries from Harm*, OEI-02-17-00021 (July, 2019).

- *Reporting requirements for hospices are insufficient to protect beneficiaries from harm.* OIG noted that Medicare hospice reporting requirements with respect to abuse, neglect, and other harm are limited only to when the abuse, neglect, or harm involves someone furnishing services on behalf of the hospice and the hospice has verified the allegation following an investigation. Moreover, OIG pointed out that Medicare reporting requirements for hospices are far more limited than those applicable to other provider types, such as nursing facilities, which must report all alleged instances of abuse, neglect, exploitation, or mistreatment to law enforcement and CMS within two hours if serious bodily injury is involved or within 24 hours otherwise. OIG also noted that reporting requirements for surveyors are also limited and that CMS's recent guidance on immediate jeopardy[3] omitted reference to reporting criminal acts to local law enforcement altogether, though CMS stated that the omission was in error.
    - Over the course of several months, a hospice patient's neighbor would enter the patient's apartment and steal his pain and anxiety medication. The hospice provider was aware of the thefts but did not plan to notify law enforcement or to ensure the patient's safety. The patient had to be admitted to a nursing facility to manage his pain.
- *Beneficiaries and caregivers faces barriers to making complaints*, an important mechanism for protecting beneficiaries. There are two primary avenues available to hospice patients, their families, and their caregivers to register complaints. They can voice a grievance with the hospice or make a complaint to the state agency. In the case of complaints made to the hospice, OIG pointed out that hospices do not always handle grievances appropriately. Moreover, if patients, their families, or their caregivers even know that they can make a complaint to the state agency, the process for doing so is confusing and decidedly user un-friendly.
    - A hospice patient was frequently in pain. The hospice thought the patient was developing a tolerance to the pain medications. The medical director refused to order different medication as recommended by the consulting pharmacy, instead suggesting medication that had made the patient sick in the past. The patient considered revoking hospice but died shortly thereafter. The family filed a grievance with the hospice but the hospice did not properly record, investigate, or address the grievance. The state agency knew nothing about the grievance until the next standard survey.
- *Surveyors did not always cite immediate jeopardy in cases of significant beneficiary harm, and CMS has inadequate options for holding hospices accountable for harming beneficiaries.* Immediate jeopardy is the most serious level of violation and means that the noncompliance placed the health and safety of patients at risk for serious injury, harm, impairment, or death. Despite the seriousness of the situations described in the 12 cases included by OIG in the Second Report, immediate jeopardy was cited in only five of the cases. More importantly, however, an immediate jeopardy citation carries no sanctions for hospice providers like it does for other provider types. Rather, the hospice must develop a removal plan that documents the immediate actions it will take to prevent serious harm from occurring or recurring.
    - A hospice failed to leave sufficient pain and anxiety medication at the patient's assisted living facility to treat the patient's pain. The facility was forced to transfer the patient to a hospital where she died a day later. The hospice was cited for failing to provide services necessary to avoid physical and mental harm but was not cited for immediate jeopardy.
    - A hospice patient with severe pain began vomiting blood. He called the hospice and was told that he would have to revoke hospice and go to the emergency room if he wanted treatment. The hospice failed to follow up with the patient until his next scheduled visit several days later. The hospice was not given an immediate jeopardy citation.
- *Plans of correction are not designed to address underlying issues.* Plans of correction respond to a specific circumstance and not the underlying issues that gave rise to the deficiency. Specifically, OIG noted that plans of correction often call for oversight, retraining, auditing or revising policies and procedures. Rarely did they call for staff discipline.
    - A hospice failed to bring in a wound care specialist for a Stage IV pressure wound. The hospice was cited for a deficiency. Its plan of correction included education, in-service training, and competency evaluations for staff on wound management. No staff member was disciplined, and no new policies were enacted to prevent similar harm from occurring in the future.

3 Revisions to Appendix Q, Guidance on Immediate Jeopardy, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Memorandum, QSO-19-09-ALL (Mar. 5, 2019).

- A hospice patient suffered a broken leg after a hospice aide tried to lift her manually (rather than with a mechanical lift) and dropped her on the floor. The patient died several days later. The hospice received an immediate jeopardy citation because 40 other patients required special transfer assistance and were at risk of harm from inadequate staff training. The hospice's plan of correction addressed training staff on the mechanical lift and having the administrator audit care plans but did not address the broader issue of the hospice sending staff to provide a service they were not trained to provide.

- *CMS cannot impose penalties—other than terminating hospices from participation in Medicare—to hold hospices accountable for harming patients.* Moreover, CMS may only terminate the provider from the Medicare program if the provider fails to comply with the survey and plan of correction process. There are no intermediate sanctions, such as civil monetary penalties or denying payment for new patients, available to incentivize providers to make systemic changes.

OIG made several recommendations to CMS, some of which have been made in previous reports.[4] These recommendations include strict requirements to report harm to CMS and law enforcement, and increasing the number of enforcement tools available to CMS. OIG also made five new recommendations:

- Strengthen requirements for hospices to report abuse, neglect, and other harm. CMS concurred with this recommendation. The agency cited the existing reporting obligation and stated that it would review its interpretive guidance for opportunities to clarify existing guidance on reporting such violations. OIG responded that the existing reporting obligation is insufficient to protect Medicare beneficiaries and thus it is recommending that CMS revise and strengthen the requirement so that hospices report suspected harm, regardless of the perpetrator.
- Ensure that hospices are educating their staff to recognize signs of abuse, neglect, and other harm. CMS concurred with this recommendation and promised to continue to provide educational materials that hospices can use to train staff.
- Strengthen guidance for surveyors to report crimes to local law enforcement. CMS concurred with this recommendation and said it would look into ways to strengthen its guidance.
- Monitor surveyors' use of immediate jeopardy citations. CMS concurred with this recommendation and stated that it will monitor state agency surveyors' use of immediate jeopardy citations.
- Improve and make user-friendly the process for beneficiaries and caregivers to make complaints. CMS partially concurred with this recommendation. The agency stated that it would look into ways to improve the complaint process "within regulatory constraints and with available resources."

By highlighting the case stories, OIG is attempting to put a face on the deficiency statistics it cited in its companion report. The two reports, taken together, while not representative of the care that most hospice patients receive, are meant to highlight the problems that OIG has raised in past reports and persuade CMS to act. Whether they actually accomplish that objective is yet to be seen; however, they also risk scaring Medicare beneficiaries and their families away from hospice as a means of caring, compassionate care at the end of life. Regardless, hospice providers will need to address performance shortcomings in order to provide the highest quality of care to these very vulnerable patients.

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

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