U.S. Department of Health and Human Services

Office of Inspector General

Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm

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What OIG Found

This report features 12 cases of harm to beneficiaries receiving hospice care. We examined each case to identify vulnerabilities that could have led to the harm and to determine how such harm could be prevented in the future.

Some instances of harm resulted from hospices providing poor care to beneficiaries and some resulted from abuse by caregivers or others and the hospice failing to take action.

These cases reveal vulnerabilities in the Centers for Medicare & Medicaid Services' (CMS's) efforts to prevent and address harm. These vulnerabilities include insufficient reporting requirements for hospices, limited reporting requirements for surveyors, and barriers that beneficiaries and caregivers face in making complaints. Also, these hospices did not face serious consequences for the harm described in this report. Specifically, surveyors did not always cite immediate jeopardy in cases of significant beneficiary harm and hospices' plans of correction are not designed to address underlying issues. In addition, CMS cannot impose penalties, other than termination, to hold hospices accountable for harming beneficiaries.

Key Takeaway

Some beneficiaries have been seriously harmed when hospices provided poor care or failed to take action in cases of abuse.

These cases reveal vulnerabilities in beneficiary protections that CMS must address, including strengthening reporting requirements, to better ensure that beneficiary harm is identified, reported, addressed, and, ultimately, prevented.

What OIG Recommends

The findings of this report provide further support for an existing Office of Inspector General (OIG) recommendation that CMS should seek statutory authority to establish additional, intermediate remedies for poor hospice performance. To effectively protect beneficiaries from harm, CMS must have enforcement tools.

In addition, we make several new recommendations to strengthen safeguards to protect Medicare hospice beneficiaries from harm: CMS should (1) strengthen requirements for hospices to report abuse, neglect, and other harm; (2) ensure that hospices are educating their staff to recognize signs of abuse, neglect, and other harm; (3) strengthen guidance for surveyors to report crimes to local law enforcement; (4) monitor surveyors' use of immediate jeopardy citations; and (5) improve and make user-friendly the process for beneficiaries and caregivers to make complaints. CMS concurred with the first four of these recommendations and partially concurred with the fifth.

Full report can be found at oig.hhs.gov/oei/reports/oei-02-17-00021.asp

Why OIG Did This Review

This report describes specific instances of harm to hospice beneficiaries and identifies vulnerabilities in CMS's efforts to prevent and address harm.

In past work, OIG raised a number of concerns about the care provided to Medicare beneficiaries. As part of a recent portfolio, OIG found that hospices did not always provide needed services to beneficiaries and sometimes provided poor quality care.

Hospice care can provide great comfort to beneficiaries, their families, and caregivers at the end of a beneficiary's life. Medicare hospice beneficiaries have the right to be free from abuse, neglect, and other harm. When hospices cause harm or fail to take action when harm is caused by others, beneficiaries are deprived of these basic rights.

This report is the second in a two-part series addressing hospice quality of care. The companion report identifies risks posed to Medicare beneficiaries from hospice deficiencies.

How OIG Did This Review

We based this report primarily on 12 cases of beneficiary harm from a review of the survey reports for a purposive sample of 50 serious deficiencies in 2016. We reviewed the survey reports and the associated plans of correction to describe the 12 cases of harm and to gain an understanding of CMS's efforts to prevent and address beneficiary harm.

We purposively selected these 12 cases for review because of the severity of harm to the beneficiary. These cases do not represent the majority of hospice beneficiaries or hospice providers. They also do not reflect the prevalence of harm to hospice beneficiaries.

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BACKGROUND

Objectives

1. To describe instances of harm to Medicare hospice beneficiaries.
2. To identify vulnerabilities in the Centers for Medicare & Medicaid Services' (CMS's) efforts to prevent and address beneficiary harm in hospice care.

Hospice is an increasingly important benefit for the Medicare population. The goals of hospice care are to make terminally ill beneficiaries with a life expectancy of 6 months or less as physically and emotionally comfortable as possible and to support their families and other caregivers throughout the process. The number of hospice beneficiaries has grown every year for the past decade. In 2017, Medicare spent $17.8 billion for hospice care for nearly 1.5 million beneficiaries, up from $9.2 billion for less than 1 million beneficiaries in 2006.

In a recent portfolio, the Office of Inspector General (OIG) synthesized its body of work on the Medicare hospice benefit and raised a number of concerns about the care provided to beneficiaries.[1] As part of this portfolio, OIG highlighted that hospices did not always provide needed services to beneficiaries and sometimes provided poor quality care.

Medicare beneficiaries who elect hospice care are an especially vulnerable population. They have the right to be free from abuse, neglect, mistreatment, and misappropriation of patient property.[2] When hospices cause harm or fail to prevent or mitigate harm caused by others, beneficiaries are deprived of these basic rights.[3]

This report is the second in a two-part series that builds on OIG's past hospice work. The first in the series focuses on the overall quality of care provided to hospice beneficiaries and the deficiencies found by surveyors

[1] This portfolio also presents recommendations to improve program vulnerabilities. See OIG, *Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio*, OEI-02-16-00570, July 2018.

[2] 42 CFR § 418.52(c)(6).

[3] OIG is also concerned about abuse and neglect of beneficiaries in skilled nursing facilities. See OIG, *Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reporting in Accordance With Applicable Requirements*, A-01-17-00504, August 2017.

who conduct onsite reviews.[4] This second report describes specific instances of harm suffered by hospice beneficiaries and identifies vulnerabilities in CMS's efforts to prevent and address harm.

The Medicare Hospice Benefit

To be eligible for Medicare hospice care, a beneficiary must be entitled to Medicare Part A and be certified as having a terminal illness with a life expectancy of 6 months or less if the illness runs its normal course.[5] Upon a beneficiary's election of hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary's terminal illness and related conditions.

Hospice care is palliative, rather than curative. It includes, among other benefits, nursing care, medical social services, hospice aide services, medical supplies (including drugs and biologicals), and physician services.[6] The beneficiary waives all rights to Medicare payment for services related to the curative treatment of the terminal condition or related conditions but retains rights to Medicare payment for services to treat conditions unrelated to the terminal illness.[7]

Hospice care may be provided in various settings, including the home or other places of residence, such as an assisted living facility or skilled nursing facility. Hospices may also have their own hospice inpatient unit, which can be freestanding or in a space shared with another healthcare provider.[8] Beneficiaries may revoke their election of hospice care and return to standard Medicare coverage at any time.[9]

The Medicare hospice benefit has four levels of care, which are paid at different rates. The levels are routine home care, continuous home care, general inpatient care, and inpatient respite care. Each level has an all-inclusive daily rate that is paid through Part A. The rate is paid to the hospice for each day that a beneficiary is in hospice care, regardless of the number of services, if any, furnished on a particular day.[10]

[4] OIG, *Hospice Deficiencies Pose Risks to Medicare Beneficiaries*, OEI-02-17-00020.

[5] Social Security Act, §§ 1814(a)(7)(A) and 1861(dd)(3)(A); 42 CFR §§ 418.20 and 418.22.

[6] Social Security Act, § 1861(dd)(1).

[7] Social Security Act, § 1812(d)(2)(A); 42 CFR § 418.24(d).

[8] 42 CFR § 418.110.

[9] Social Security Act, § 1812(d)(2)(B); 42 CFR § 418.28.

[10] 42 CFR § 418.302. For continuous home care, the hospice is paid an hourly rate based on the number of hours of continuous care furnished to the beneficiary on that day. CMS, *Medicare Claims Processing Manual*, Ch. 11, § 30.1.

Survey and Certification Process

To participate in Medicare, hospices must be certified as meeting certain Federal requirements—called Conditions of Participation (CoPs). The CoPs consist of standards for health and safety.[11] For example, the hospice CoP for infection control includes a standard for prevention, a standard for control, and a standard for education. The requirements are intended to ensure the quality of care and services provided by hospices. Beginning in April 2015, hospices must be surveyed at least once every 3 years to verify their compliance with these requirements.[12]

CMS contracts with State agencies and grants approval to accrediting organizations to survey hospices to ensure that they comply with Federal requirements.[13] Hospices choose to have the survey conducted either by State agencies or—for a fee—a CMS-approved accrediting organization. As part of this process, surveyors gather information necessary to determine whether the hospice is providing appropriate care. For example, they conduct home visits and interviews with patients and staff, as well as observe the facility's condition and operations.[14] Surveyors document their official findings in a "survey report."

In addition to standard surveys, hospices may be inspected due to a complaint from beneficiaries, caregivers, healthcare providers, or others.[15] CMS tracks these complaints, categorizing them into different severity levels to determine which actions to take.[16] For more severe complaints, CMS requires the State agency to conduct onsite surveys to investigate within certain timeframes.

Deficiencies

If surveyors determine that a hospice fails to meet a requirement during either a standard survey or complaint investigation, surveyors cite the hospice with a condition-level or standard-level deficiency.[17] A condition-level deficiency—the most serious deficiency—is cited when the

[11] Social Security Act, § 1861(dd)(2). 42 CFR part 418, subparts C and D set forth the CoPs for hospices.

[12] Social Security Act, § 1861(dd)(4)(C). The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) established the requirement that Medicare hospices must be surveyed at least every 3 years. Prior to this Act, neither law nor regulation specified the frequency of Medicare surveys for hospices. See also, 42 CFR § 488.5(a)(4)(i).

[13] Social Security Act §§ 1864 and 1865.

[14] CMS, *State Operations Manual (SOM)*, Appendix M.

[15] CMS, *SOM,* Ch.5, § 5000.

[16] CMS, *SOM*, Ch.5, § 5010. "Immediate jeopardy" (IJ) and "non-IJ high" (very high concern) are the highest severity levels. See CMS, *SOM*, Ch.5, §§ 5075.1 and 5075.2.

[17] 42 CFR § 488.26(b).

hospice violates one or more standards, which substantially limits its capacity to furnish adequate care or adversely affects the health and safety of patients.[18]

After a hospice is cited with a deficiency, it must submit a plan of correction to the State agency.[19] This plan of correction explains how the hospice will address each deficiency, including procedures to ensure that they remain corrected.

Immediate Jeopardy

Immediate jeopardy is a situation where a hospice's noncompliance with one or more CoPs has placed the health and safety of beneficiaries at risk for serious injury, harm, impairment, or death.[20] When a surveyor identifies an immediate jeopardy situation, the hospice must take immediate corrective action to prevent the situation from recurring.[21]

Methodology

We based this report primarily on a review of 12 cases of beneficiary harm. We selected these cases from a review of the survey reports for a purposive sample of 50 serious (i.e., condition-level) deficiencies in 2016.[22] We conducted the review of the 50 serious deficiencies for the analysis for the first report in this series on the overall quality of care provided to hospice beneficiaries and the deficiencies found by surveyors who conduct onsite reviews. See *Hospice Deficiencies Pose Risks to Medicare Beneficiaries*, OEI-02-17-00020, for more information about the methodology.

We selected the 12 cases for review because of the severity of harm to the beneficiary. We reviewed the survey reports for these 12 cases to describe and characterize the harm and to gain an understanding of CMS's efforts to prevent and address beneficiary harm. We examined each case to identify vulnerabilities in these efforts that could have led to the harm and to determine how such harm could be prevented in the future. We reviewed the associated plans of correction submitted by the hospices to assess their responses. The 12 cases of harm are associated with different hospices throughout the country.

In addition, we analyzed data in CMS's Certification and Survey Provider Enhanced Reports (CASPER), which contains the deficiency data for hospices surveyed by State agencies. We used these data to determine for each case

[18] 42 CFR § 488.24(b).

[19] 42 CFR § 488.28(a). See also CMS, *SOM*, Ch. 2, § 2728B.

[20] 42 CFR § 489.3. See also CMS, *SOM,* Appendix Q.

[21] CMS, *SOM,* Appendix Q.

[22] Hospices were cited with 248 serious deficiencies by the State agencies in 2016.

of harm, whether the surveyor cited the hospice for immediate jeopardy and whether the harm was identified through a complaint or through a standard survey conducted by the State agency. For cases identified through a complaint, we also analyzed data in the Automated Survey Processing Environment (ASPEN) Complaints/Incidents Tracking System to determine whether the complaint was made by a family member, the hospice itself, or another source.

Lastly, we reviewed the CoPs, the *SOM* for State agencies, and other relevant guidance.

Limitations

The 12 cases of harm featured in this report do not represent the majority of hospice beneficiaries or the majority of hospice providers. Due to the purposive sampling of deficiencies, we cannot determine the prevalence of harm suffered by all hospice beneficiaries. Additionally, we did not independently verify the accuracy of the information included in the survey reports.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

When a beneficiary elects hospice care, the hospice is responsible for providing all services related to the beneficiary's terminal illness and related conditions. When a hospice does not comply with Medicare requirements, there can be significant consequences for the beneficiary. This report features 12 cases of beneficiary harm that we identified in our review of serious hospice deficiencies in 2016. In these cases, hospices provided poor care or failed to take action when beneficiaries were abused by caregivers or others, leaving them to suffer unnecessarily. In some cases, the suffering prompted the beneficiaries to revoke the hospice benefit in an effort to get some relief.

Although these cases do not represent the majority of hospice beneficiaries or the majority of hospice providers, any instance of harm must be taken seriously. Moreover, these cases reveal vulnerabilities in CMS's efforts to prevent and address harm that have implications for the wider hospice population.

Some instances of harm resulted from hospices providing poor care to beneficiaries

In the cases below, hospices provided such poor care that beneficiaries were seriously harmed, causing them to suffer unnecessarily. These cases involve beneficiaries not receiving adequate services to care for wounds, a feeding tube insertion site, and respiratory issues.

Case 1: The hospice did not treat a beneficiary's wounds, which became gangrenous

A beneficiary with Alzheimer's disease developed pressure ulcers to both heels 2 weeks after starting hospice care. The ulcers rapidly worsened over the next several days and the beneficiary was admitted to the hospital for a high level of hospice care called general inpatient care. The beneficiary developed gangrene—the death of tissue—and subsequently needed the lower left leg amputated. This beneficiary revoked hospice.

Case 2: The hospice allowed maggots to develop around a beneficiary's feeding tube

While under the care of a hospice in his home, a beneficiary developed maggots around his feeding tube insertion site and had to be transferred to the hospital for treatment. His caregiver indicated that the beneficiary experienced pain when moved due to a pressure sore and contractures, and specifically mentioned that one reason the

beneficiary was in hospice care was to avoid unnecessary pain and trauma associated with hospitalizations.

Case 3: The hospice did not provide necessary respiratory therapy services

A beneficiary elected hospice primarily to receive respiratory therapy services. He relied on oxygen via nasal cannula around the clock and an albuterol inhaler for shortness of breath. The initial plan of care specified that the beneficiary should receive respiratory therapy one to three times a month. However, the beneficiary received no respiratory therapy for over 2 months. During this time, a registered nurse noted the beneficiary had to make increasing efforts to breathe, had greater fatigue, had grown gaunter in his face, and had an increasing grey color to his skin. The beneficiary decided to discontinue hospice entirely given the poor service he received.

Some instances of harm resulted from abuse by caregivers or others and the hospice failing to take action

In several of the cases, the hospices did little to protect beneficiaries when caregivers or others were abusing them.

Case 4: The hospice failed to recognize signs of a possible sexual assault of a beneficiary

A beneficiary residing in an assisted living facility had blood clots and significant signs of injury to her pelvic area, right upper leg, and right forearm. Hospice staff failed to recognize these as signs and symptoms of possible sexual assault and did not report them to the hospice administrator or local law enforcement agency. Instead, the hospice obtained a physician's order for the insertion of a urinary catheter, an invasive procedure. The hospice tried and failed multiple times to insert a catheter, finally transferring the beneficiary to a hospital. The hospital staff recognized the signs of possible sexual assault and notified the police.

Case 5: The hospice did not intervene when a beneficiary was harmed by his caregiver

A beneficiary lived at home with his son, who was also his caregiver. The son would allow the beneficiary to get up on his own, causing him to fall, and then would not help the beneficiary up. The son would also sometimes make the beneficiary clean his own dirty briefs. A social worker had identified caregiver burnout as a problem, but the hospice did not make any changes to the beneficiary's care plan. The hospice also did not provide inpatient respite care, the level of hospice care designed to provide relief to the caregiver by placing the beneficiary in an inpatient facility for a short stay.

Case 6: The hospice did not take action when a beneficiary was abused by her daughter

A beneficiary was consistently abused by her daughter, who was acting as her caregiver. The daughter would use a chain and elastic seatbelt to keep the beneficiary from getting out of bed. The daughter would also leave her mother in a wheelchair in the bathroom with the lights off and would spray her with water when she called out for help. Further, the daughter refused changes to her mother's drug regimen that left the beneficiary lethargic and weak because the daughter preferred to keep her mother sedated. The hospice's social worker did not visit the beneficiary until several weeks after being notified of the signs of abuse and did not assess the beneficiary's safety during his visit.

Reporting requirements for hospices are insufficient to protect beneficiaries from harm

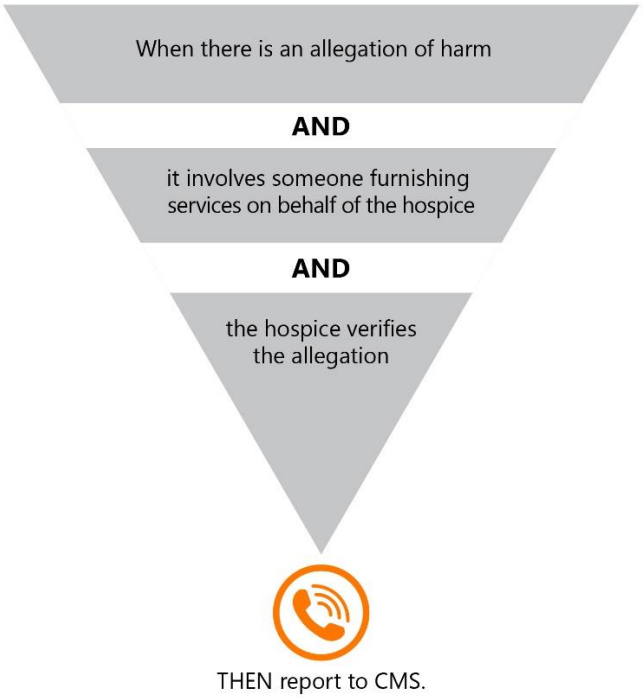
The 12 cases featured in this report reveal vulnerabilities in CMS's efforts to prevent and address beneficiary harm in hospice care. One of these vulnerabilities is that the Medicare requirements for hospices to report beneficiary harm are limited. Of the 12 cases, just one hospice reported harm to CMS.

Reporting to CMS and law enforcement can be crucial to protecting hospice beneficiaries, who are often bed-bound, cognitively impaired, and reliant on caregivers. CMS has acknowledged the value of requiring Medicare providers to report beneficiary harm, as such reporting allows CMS to conduct surveys to ensure that providers are complying with health and safety regulations and to partner with law enforcement agencies, if appropriate.[23]

However, CMS requires a hospice to report abuse, neglect, and other harm in only one circumstance: when it involves someone furnishing services on behalf of the hospice and the hospice has investigated and verified the allegation. See Appendix A for the text of this requirement and the Figure.

[23] Statement of Dr. Kate Goodrich, CMS Chief Medicare Officer, on "Not Forgotten: Protecting Americans from Abuse and Neglect in Nursing Homes" before the U.S. Senate Finance Committee, March 6, 2019.

Figure. Only in limited circumstances are hospices required to report beneficiary harm to CMS:



There is no other explicit Medicare requirement for the hospice to report harm to CMS or law enforcement, except for certain types of harm that occur within a long-term-care facility.[24, 25]

The shortcomings of the current reporting requirements are illustrated by one hospice's response to its survey. In this instance, Case 4 above, the beneficiary showed signs of possible sexual assault and the hospice was cited for failing to investigate the allegation of abuse. In response, the hospice stated that it disagreed with the survey finding because it was never alleged that a hospice employee was responsible for abusing the beneficiary. In other words, the hospice claims that it had no obligation to investigate the possible sexual assault of a beneficiary in its care because an accusation had not been leveled at a hospice employee. If the allegation does not involve someone furnishing services on behalf of the hospice and is not investigated and verified, the hospice would not have an obligation to report the harm to CMS.

[24] 42 CFR § 418.52(b)(4)(iv). CMS requires hospices to comply with State and local laws and regulations related to patient health and safety. 42 CFR § 418.116. Individual States may have requirements to report to law enforcement or adult protective services.

[25] There are also reporting requirements for hospice employees in certain limited circumstances. Covered individuals (including employees) in long-term-care facilities shall report reasonable suspicions of a crime against any individual who is a resident of, or receiving care from, that facility. Social Security Act § 1150B.

Another case that demonstrates the limitations of the current reporting requirements is provided below.

Case 7: The hospice did not address the repeated theft of a beneficiary's medications, leaving him in emotional and physical distress

Over several months, a beneficiary's neighbor frequently came into his apartment unannounced—naked, high, and drunk—and stole his medications, including an opioid and an anti-anxiety medication. This caused the beneficiary to feel stressed, anxious, and short of breath. Several hospice employees were aware of the situation. The beneficiary was admitted to a nursing facility for 5 days for pain management because his medications had been stolen, but the hospice planned no further actions to notify law enforcement or to ensure the beneficiary's safety.

The Medicare reporting requirements for hospices are far more limited than reporting requirements for some other provider types. For example, nursing facilities must report all alleged violations—not just verified ones—involving abuse, neglect, exploitation, or mistreatment immediately to officials, including CMS.[26] This process provides increased protection for beneficiaries and allows the proper authorities, including CMS and law enforcement, to investigate and determine the best course of action. CMS has noted that increased protection for nursing facility residents is warranted because of particular risk to these beneficiaries.[27]

As with nursing facility residents, hospice beneficiaries are extremely vulnerable. As previously stated, hospice beneficiaries are often bed-bound, cognitively impaired, and reliant on caregivers. They receive their care in nursing facilities, hospice inpatient units, and their homes. Reported cases of abuse and neglect in nursing facilities are similar to the cases involving hospice beneficiaries described in this report.[28] Hospice beneficiaries have

[26] Reports must be made within 2 hours if an allegation involves abuse or resulted in serious bodily injury and within 24 hours otherwise. See 42 CFR § 483.12(c).

[27] CMS, *The Urgent Work Of Patient Safety Improvement In Nursing Homes: CMS Responds To Brauner And Colleagues*, Health Affairs Blog, January 31, 2019. Accessed at https://www.healthaffairs.org/do/10.1377/hblog20190125.451315/full/ on March 7, 2019.

[28] OIG, *Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reporting in Accordance With Applicable Requirements*, A-01-17-00504, August 2017.

the right to be free from such harm, and hospices are required to protect and promote the exercise of beneficiaries' rights.[29]

Reporting requirements for surveyors are also limited

Another vulnerability in CMS's efforts to prevent and address harm is the lack of requirements for surveyors to report crimes to law enforcement. During the course of their reviews, surveyors may discover beneficiary harm that may have resulted from a crime. Until recently, the only guidance provided to surveyors was in the limited context of immediate jeopardy situations.[30] Specifically, the guidance stated that in the case of immediate jeopardy situations, the surveyor was responsible for reporting criminal acts to local law enforcement only if the hospice refused to report the crime itself.

On March 5, 2019, CMS published new guidance for surveyors to handle immediate jeopardy situations. The guidance no longer makes reference to contacting law enforcement.[31] According to CMS, the deletion of this reference was an error, and it is working to rectify it through revised guidance.

In contrast, CMS provides more specific guidance for surveyors for nursing facilities. This guidance states that surveyors are required to report to law enforcement all substantiated findings of abuse.[32]

Beneficiaries and caregivers face barriers to making complaints, which are an important mechanism for protecting beneficiaries

Another vulnerability in efforts to prevent and address harm is that beneficiaries, their caregivers, and their families face barriers to making complaints. Beneficiaries and others have two primary avenues for registering complaints about the quality of care a hospice provides: they can voice a grievance with the hospice and they can make a complaint to the State agency.[33] Complaints are an important mechanism for protecting beneficiaries from harm.

[29] 42 CFR § 418.52.

[30] This guidance to surveyors was in a note in a section about procedures to follow if immediate jeopardy was found. CMS, *SOM*, Appendix Q—Guidelines for Determining Immediate Jeopardy, § VI—Implementation, A—Team Actions. However, this guidance was replaced with new guidance effective March 5, 2019.

[31] CMS, *Revisions to Appendix Q, Guidance on Immediate Jeopardy*, Memorandum to State Survey Agency Directors, March 5, 2019. Accessed at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-09-ALL.pdf on March 7, 2019.

[32] CMS, *SOM*, Ch. 5, § 5330.

[33] 42 CFR § 418.52(b)(1)(iii); CMS, *SOM*, Ch. 5 § 5000.

A number of barriers exist for beneficiaries and others to make complaints. First, although some hospices provide information about how to make a complaint when beneficiaries elect hospice care, it is not required.[34] Further, this information is not otherwise easily accessible via Hospice Compare—CMS's primary website for sharing quality-of-care information about hospices. See text box for Hospice Compare's instructions for making complaints. Second, hospices do not always handle grievances appropriately even when beneficiaries file them. See Case 8 below for an example. Third, beneficiaries and their families may not understand the State agency's role in oversight, and may not know that they can make complaints to the agency. Because the complaint process can be confusing, many beneficiaries or others may not understand how to make complaints at all when they receive poor care.

Instructions on Hospice Compare for making a complaint are unclear and burdensome

- A link to "file a complaint about hospice services" leads to a page encouraging those with a quality-of-care complaint to contact their own hospice. It is not possible to file a complaint via this link.
- Another link to "get information about filing a complaint" leads to a general Medicare page about the different types of complaints. It is not possible to file a complaint via this link.
- The series of confusing links on the site may deter beneficiaries or others from making complaints at all.

The cases featured in this report show that beneficiaries and others do not always file complaints when a beneficiary is seriously harmed. Notably, of the 12 cases, 7 were exposed as a result of a specific complaint, usually made by a family member. The remaining cases of harm were discovered through standard surveys. A standard survey of a hospice is conducted every 3 years by the State agency or accrediting organization to assess the quality of care provided to beneficiaries. These surveys involve only a small number of beneficiaries.[35] The serious nature of the harm described in this report and the fact that five of these cases were not associated with complaints raise questions about the ease and effectiveness of the complaint process.

[34] OIG, *Hospices Should Improve Their Election Statements and Certifications of Terminal Illness*, OEI-02-10-00492, September 2016.

[35] The minimum number of records to be reviewed ranges from 11 records for less than 150 admissions to 20 records for over 1,250 admissions in a recent 12-month period. CMS, *SOM*, Appendix M.

The following case demonstrates some of the difficulties in making an effective complaint.

Case 8: A hospice mismanaged the grievance a family filed over poor pain control

A beneficiary was bed-bound and frequently in pain—often rating it between 5 and 7 on a scale of 10. The hospice staff thought he was developing a tolerance to his current pain medications. The hospice medical director refused to order different medications recommended by a consulting pharmacy, instead suggesting other medications that had made the beneficiary sick in the past. The beneficiary considered revoking hospice because he wasn't getting the pain control he needed. He died shortly after. The family had filed a grievance with the hospice, but the hospice did not properly record, investigate, or address the grievance. The family did not complain directly to the State agency, which was unaware of the harm suffered by this beneficiary until it conducted a standard survey.

None of these hospices faced serious consequences for harming beneficiaries

An additional vulnerability in efforts to prevent and address harm is that hospices responsible for harming beneficiaries are not always held accountable in a meaningful way. None of the hospices associated with the 12 cases in this report faced serious consequences from CMS for causing the harm described.

Serious consequences for causing harm would help ensure that hospices do not repeat specific instances of harm and that they address underlying issues to protect every beneficiary in their care. Immediate jeopardy citations and plans of correction are the main tools that CMS has to hold hospices accountable for their actions. However, these tools are limited, particularly because the only penalty available to CMS is termination from the Medicare program, which is rarely used.

Surveyors did not always cite immediate jeopardy in cases of significant beneficiary harm

The most serious determination that a surveyor can make is to cite immediate jeopardy, which means that the hospice's noncompliance with a CoP placed the health and safety of beneficiaries at risk for serious injury, harm, impairment, or death. However, immediate jeopardy is not always cited when a beneficiary is harmed. In each of the 12 cases featured in this report, the beneficiary experienced significant harm, but only 5 of the

hospices were cited for immediate jeopardy.[36] The other seven hospices were not. Two such cases are below.

Case 9: The hospice did not provide essential pain management services, yet was not cited for immediate jeopardy

A beneficiary in an assisted living facility (ALF) was agitated and crying out in pain late at night. A registered nurse instructed a medication aide to administer anti-anxiety medication, but none had been left at the ALF for this beneficiary and a dose was borrowed from another patient. Two hours later, the beneficiary was still in pain, but there was not enough morphine available to increase her dose. The ALF sent her to a hospital emergency room, instead, for pain relief. There, the beneficiary revoked hospice and died the next day. The hospice was cited for failing to provide services necessary to avoid physical and mental harm, but was not cited for immediate jeopardy.

Case 10: The hospice did not provide care to a beneficiary who was vomiting blood, yet was not cited for immediate jeopardy

Upon receiving hospice services at home, a beneficiary rated his pain a 10 on a scale of 0–10. A few days later, he called the hospice to say he was vomiting frequently, sometimes with blood. He was told that he could revoke hospice and go to the emergency room because there was not much to be done at home. The beneficiary did not want to revoke hospice, and instead, his pain and vomiting remained uncontrolled. No one from the hospice followed up with the beneficiary until his next scheduled visit several days later. This hospice did not receive an immediate jeopardy citation.

According to CMS, immediate jeopardy represents the most severe and egregious threat to the health and safety of beneficiaries, as well as carries the most serious sanctions for providers.[37] Although this is true for some types of providers, immediate jeopardy carries no sanctions for hospice providers. Immediate jeopardy merely requires the hospice to develop a removal plan documenting the immediate actions it will take to prevent serious harm from occurring or recurring.

[36] The hospices associated with cases 1–3, 11, and 12 were cited for immediate jeopardy.

[37] CMS, *Revisions to Appendix Q, Guidance on Immediate Jeopardy*, Memorandum to State Survey Agency Directors, March 5, 2019. Accessed at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-09-ALL.pdf on March 7, 2019.

Hospices' plans of correction are not designed to address underlying issues

When it is cited with a deficiency, a hospice is required to submit a plan of correction that explains how it would resolve the deficient practices. The plan is designed to address a specific circumstance; it is not designed to resolve the underlying issues that gave root to the deficiencies and may continue to cause harm to other beneficiaries.

For the 12 cases in this report, the plans of correction generally involved oversight, retraining, and auditing. The plans of correction generally addressed specific circumstances rather than the underlying problems. In a few instances, the plans included the development of new hospice policies. Only rarely—twice in the 12 cases—were individual staff members disciplined for harming beneficiaries. In addition, CMS cannot always ensure that some of the corrective steps outlined in the plans are actually taken (e.g., when a plan of correction proposes to increase auditing over an extended period of time).

The following cases demonstrate the limitations of the plans of correction developed by hospices responsible for harming beneficiaries in their care. In each case, the plan did not go beyond the specific circumstances to address broader structural or administrative problems that allowed the harm to occur. The plans also did not include disciplinary actions to hold specific individuals accountable.

Case 11: The hospice did not provide necessary wound care for 2 years

A hospice beneficiary with Parkinson's and Alzheimer's disease had a Stage IV wound—the most serious and painful—on her tailbone. In the 2 years since electing hospice, she had received only morphine for her pain. She had not been seen by a wound specialist, even though wound management is fundamental to end-of-life care and she was treated by a specialist prior to electing hospice care. The hospice was cited for a deficiency.

In this case, the hospice's plan of correction included education, in-service training, and competency evaluations for all staff on wound management—steps the hospice should have been taking routinely. The plan of correction did not address underlying issues that led the hospice over the course of 2 years to repeatedly send untrained or incompetent staff to care for an extremely vulnerable beneficiary. The plan addressed the wound care issue to some degree, but questions remain as to what other training the hospice's aides lacked and what factors contributed to a beneficiary receiving poor care for such an extended period of time. None of the staff members responsible for this beneficiary were disciplined in any way, and no new policies were enacted to prevent similar harm in the future.

Case 12: The hospice did not train its staff adequately, resulting in a beneficiary's broken leg during a transfer

A beneficiary under the care of a hospice required two persons to assist with transfers using a mechanical lift. A hospice aide said she used a mechanical lift to transfer the beneficiary, and when the beneficiary complained of pain, she lowered the beneficiary to the floor and called for help. However, the beneficiary said that the hospice aide picked her up from the wheelchair under her arms and tried to put her in bed but dropped her on the floor instead. An x-ray indicated the beneficiary suffered a fracture of the right femur. The beneficiary died 10 days later. This incident resulted in an immediate jeopardy citation, as 40 beneficiaries at this hospice required special transfer assistance and were at risk of harm because many of the hospice employees were not properly trained.

In this case, the hospice's plan of correction addressed transfers, including actions such as training staff on the mechanical lift and having the hospice administrator audit care plans for beneficiaries requiring safe transfers. The plan of correction did not address the broader issue of the hospice sending staff to provide a service that they were not trained to provide.

CMS cannot impose penalties—other than terminating hospices—to hold hospices accountable for harming beneficiaries

CMS has the authority to terminate hospice providers from the Medicare program. CMS may take this step only if the provider fails to comply with the survey and plan of correction process—for example, by not submitting an adequate plan of correction in a timely manner. CMS has no other penalties at its disposal.

None of the hospices described in this report were terminated or faced a penalty for causing the harm described in this report. For instance, the hospice featured in Case 12 determined that a beneficiary needed a particular service, yet assigned an aide who could not perform that service. This hospice did not face any penalty or other deterrent against similar actions in the future, though it put at risk dozens more beneficiaries with the same needs. Further, the hospice featured in Case 11 did not provide a beneficiary proper wound care for 2 years but was not fined or held accountable in any other meaningful way. Similarly, CMS could not fine or impose other penalties in the remaining cases in which hospices allowed wounds to become gangrenous, allowed maggots to develop, took no action in cases of abuse, failed to provide needed services, mismanaged grievances, and did not recognize a possible sexual assault.

Other than termination, CMS has no tool available to hold hospices accountable for harming beneficiaries. By contrast, nursing facilities face

consequences commensurate with the degree of harm. For example, a nursing facility that places one beneficiary at risk of harm may face a civil monetary penalty, while a nursing facility that harms several beneficiaries may face temporary management and denial of new payments until systemic problems are corrected. Without these tools for hospices, CMS's ability to protect beneficiaries from harm is limited.

CONCLUSION AND RECOMMENDATIONS

This report features 12 cases of hospice beneficiaries suffering significant harm. Some instances of harm resulted from hospices providing poor care to beneficiaries and some resulted from abuse by caregivers or others and the hospice failing to take action. The cases reveal vulnerabilities in CMS's efforts to prevent and address harm that have implications for the wider hospice population.

Vulnerabilities in preventing and addressing beneficiary harm include insufficient reporting requirements for hospices and limited reporting requirements for surveyors. In addition, beneficiaries and caregivers face barriers to making complaints. Another vulnerability is that hospices do not always face serious consequences for harming beneficiaries. Specifically, surveyors do not always cite immediate jeopardy in cases of significant harm, hospices' plans of correction are not designed to address underlying issues, and, other than termination, CMS has no penalties to hold hospices accountable for harming beneficiaries.

These findings are further supported by previous OIG work. The companion report to this one found that a majority of hospices had deficiencies in the quality of care they provided, including 20 percent with serious deficiencies.[38] Also, in a recent hospice portfolio, OIG reported that hospices did not always provide needed services to beneficiaries and sometimes provided poor quality care.[39]

CMS has stated that safety cannot be compromised in America's healthcare system.[40] In an effort to ensure that immediate jeopardy situations are identified and handled consistently, CMS recently revised its guidance to State agencies that survey Medicare providers. CMS has also recognized the issue of beneficiary harm in nursing facilities and, in testimony before Congress, discussed various safeguards in place to decrease harm at these facilities. One such safeguard is that nursing facilities have strict requirements to report harm to CMS and law enforcement so that appropriate steps can be taken. Another safeguard is that CMS has a number of enforcement tools, such as civil monetary penalties or temporary

[38] OIG, *Hospice Deficiencies Pose Risks to Medicare Beneficiaries*, OEI-02-17-00020.

[39] OIG, *Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio*, OEI-02-16-00570, July 2018.

[40] CMS, *Protecting the Health and Safety of All Americans*, Press Release, March 5, 2019. Accessed at https://www.cms.gov/blog/protecting-health-and-safety-all-americans on March 7, 2019.

management, which can be used when nursing facilities do not comply with Medicare regulations.[41]

We urge CMS to extend these protections to hospice beneficiaries. This report and its companion demonstrate the need for these additional safeguards for the hospice population. These beneficiaries are especially vulnerable and should be protected from harm. The reports also make clear the need to hold hospices accountable when they do not meet their responsibilities. CMS's ability to do so hinges on it having enforcement tools similar to those available for its oversight of nursing facilities.

Accordingly, as OIG has previously recommended, CMS should seek statutory authority to establish additional, intermediate remedies for poor hospice performance.[42]

> Existing recommendation from prior OIG work that addresses these findings:
>
> CMS should seek statutory authority to establish additional, intermediate remedies for poor hospice performance

In addition, we make several new recommendations to strengthen safeguards. These recommendations involve hospice requirements, CMS's oversight of the State agency surveyors, and the process for hospice beneficiaries and their caregivers to make complaints. Specifically, we recommend that CMS:

Strengthen requirements for hospices to report abuse, neglect, and other harm

Reporting harm is crucial for CMS to determine the appropriate interventions, hold hospices accountable, and prevent such harm in the future. To ensure appropriate reporting, CMS should strengthen the requirements for hospices to report possible abuse, neglect, and other harm.

Specifically, CMS should strengthen the hospice Condition of Participation related to the reporting of abuse, neglect, and other harm.[43] The revised CoP should require hospices to report suspected harm—regardless of perpetrator—to CMS, and law enforcement if appropriate, within short

[41] Statement of Dr. Kate Goodrich, CMS Chief Medicare Officer, on "Not Forgotten: Protecting Americans from Abuse and Neglect in Nursing Homes" before the U.S. Senate Finance Committee, March 6, 2019.

[42] OIG, *Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio*, OEI-02-16-00570, July 2018.

[43] 42 CFR § 418.52(b)(4).

timeframes. This puts CMS in a position to determine whether harm occurred, whether the hospice played a role in that harm, and, if so, which remedies are appropriate. Other Medicare providers, such as skilled nursing facilities, already have such requirements in their CoPs and should be used as a model for revising the hospice CoP.

CMS should also strengthen the hospice CoPs by including a requirement that hospices develop written policies and procedures for investigating and reporting suspicions of abuse, neglect, and other harm. Nursing facilities are currently required to have such policies and procedures. Finally, the CoPs should include a requirement that hospices develop training for employees regarding signs of abuse, neglect, and other harm, their obligation to report suspicions of abuse, neglect, and other harm, and how to make such reports. Hospices should create a schedule for providing this training to employees periodically.

Ensure that hospices are educating their staff to recognize signs of abuse, neglect, and other harm

Hospice staff are uniquely positioned to witness or see evidence of beneficiary harm while caring for beneficiaries, and they should be knowledgeable about such issues. To help ensure that hospice staff recognize harm and to assist hospices in training efforts, CMS should provide hospices with educational materials and other information that hospices can use when training their employees. CMS could consider consulting the Administration on Aging's National Center on Elder Abuse for assistance in developing such educational materials.

Strengthen guidance for surveyors to report crimes to local law enforcement

Surveyors can act as further protection for beneficiaries by reporting cases of possible crime to local law enforcement. Accordingly, CMS should add back to its State Operations Manual instructions for surveyors to contact law enforcement when appropriate. In updating the instructions, CMS should expand upon the previous guidance, which was limited in that it applied only to immediate jeopardy situations and required reporting only if the hospice refused. CMS should ensure that surveyors or State agencies are required to always contact law enforcement if they suspect a crime was committed, regardless of a finding of immediate jeopardy.

Monitor surveyors' use of immediate jeopardy citations

Surveyors did not always cite immediate jeopardy in cases of significant beneficiary harm. CMS recently issued new guidance for State agencies regarding immediate jeopardy to ensure that the most serious cases of harm are identified and handled urgently and consistently. CMS should monitor surveyors' use of immediate jeopardy in hospices under the new guidance to ensure that it is being used to identify the most serious cases of

harm. If immediate jeopardy is not being used appropriately, CMS should consider further steps it might take, including adding a hospice-specific subpart to its guidance to clarify what constitutes an immediate jeopardy situation in the hospice setting.

Improve and make user-friendly the process for beneficiaries and caregivers to make complaints

It is important that hospice beneficiaries, families, and other caregivers are able to make complaints about the quality of care received, as complaints are another source of protection for beneficiaries. Currently, the process for making a complaint is opaque and it is not clear which entity to contact with a complaint.

CMS should improve the process for making complaints and make it more accessible to beneficiaries and caregivers. CMS should assess the feasibility of making available online a standardized, centralized complaint form that can be filled out and submitted. The complaint should then be routed directly to the appropriate agency.

In addition, CMS should make the relevant State agency's phone number more easily available online. Further, CMS should work with hospices to provide information about making complaints—relevant phone numbers, websites, and forms—to beneficiaries and their caregivers when hospice is elected. Finally, CMS should include information about making complaints in its educational materials explaining the hospice benefit.

AGENCY COMMENTS AND OIG RESPONSE

This report features 12 cases of serious harm to Medicare hospice beneficiaries. Although these cases do not represent the majority of hospice beneficiaries or hospice providers, we use them to identify vulnerabilities in CMS's efforts to prevent and address beneficiary harm in hospice care and to make recommendations to strengthen safeguards for beneficiaries. CMS concurred with four of our new recommendations and partially concurred with the fifth.

CMS concurred with our first recommendation to strengthen requirements for hospices to report abuse, neglect, and other harm. CMS stated that hospices are required under 42 CFR § 418.52(b)(4) to ensure that verified violations are reported to state and local bodies having jurisdiction (including to the State agency). CMS further stated that it will review its interpretive guidance for opportunities to clarify existing guidance on reporting these violations. We note that our finding shows that this requirement—42 CFR § 418.52(b)(4)—is insufficient to protect beneficiaries because it requires hospices to report harm in only one circumstance: when it involves someone furnishing services on behalf of the hospice and the hospice has investigated and verified the allegation. As such, our recommendation is to revise and strengthen the requirement itself so that hospices report suspected harm, regardless of perpetrator, within short timeframes.

CMS concurred with our second recommendation to ensure that hospices are educating their staff to recognize signs of abuse, neglect, and other harm. CMS stated that it will continue to provide educational materials that hospices can use when training their employees.

CMS concurred with our third recommendation to strengthen guidance for surveyors to report crimes to local law enforcement. CMS stated that it will look into ways to strengthen this guidance. CMS concurred with our fourth recommendation, stating it will monitor State agency surveyors' use of immediate jeopardy citations in hospices.

CMS partially concurred with our fifth recommendation to improve and make user-friendly the process for beneficiaries and caregivers to make complaints. CMS stated that it will look into ways to improve the complaint making process for beneficiaries and caregivers within regulatory constraints and with available resources. For example, it will review existing educational materials, such as the Hospice Handbook to see if it should be updated to be more user-friendly. Although improving the Hospice Handbook is one helpful step, we found that beneficiaries and caregivers face a number of barriers to making complaints, particularly online. We recommend that CMS take additional steps to improve the complaint process. Suggestions

for these additional steps include assessing the feasibility of a standardized complaint form, making State agency phone numbers more easily available, and working with hospices to provide information about making complaints to beneficiaries and their caregivers.

See Appendix B for the full text of CMS's comments.

APPENDIX A: Hospice Reporting Requirements

§ 418.52 Condition of participation: Patient's rights.

(b) Standard: Exercise of rights and respect for property and person.

(4) **The hospice must**:

(i) Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator;

(ii) **Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice** and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures;

(iii) Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency; and

(iv) **Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation.**

[emphasis added]

APPENDIX B: Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN - 3 2019

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries from Harm (OEI-02-17-00021)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to providing Medicare beneficiaries in hospice with high-quality care.

Every hospice serving Medicare beneficiaries is required to keep its patients safe and free from harm. Abuse and mistreatment of hospice beneficiaries is never tolerated by CMS and the agency takes any allegation of these types of incidents very seriously. All twelve cases of beneficiary harm identified by the OIG were based on a selective sample of the most serious cases of beneficiary harm found during hospice surveys conducted by state survey agencies. In these cases, the state survey agency went onsite to investigate the issue, cited these hospices for failing to meet applicable conditions of participation in the Medicare and/or Medicaid programs, and verified the issue was either corrected or the hospice was terminated. CMS has reviewed the cases to further ensure appropriate action was taken by the state agencies.

We know that choosing to start hospice care is a difficult decision for beneficiaries and their families. Each hospice patient has the right to receive effective pain control and symptom control from the hospice and be free from mistreatment, neglect, or abuse. While these cases that were identified during surveys of hospices are very serious, we want to reassure beneficiaries considering hospice care that these cases are not indicative of the type of care the majority of hospice beneficiaries receive.

Monitoring patient safety and quality of care in hospices is an essential part of CMS's oversight efforts and requires coordination between the federal government and the states. CMS oversees hospice providers through the survey and certification process. State agencies and national accrediting organizations are required to conduct surveys of hospices to ensure they provide all required services and meet all hospice conditions of participation before hospices are certified for participation in Medicare, and at least every three years thereafter. In addition, beneficiaries, caregivers, and others may file complaints against hospices at any time.[1] State agencies and

[1] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Complaintcontacts.pdf

accrediting organizations will prioritize and investigate such complaints, including through conducting onsite surveys, based on the seriousness of the allegations.

When a hospice's noncompliance with one or more requirements of participation has placed the health and safety of residents at risk of serious injury, harm, impairment, or death, surveyors must identify the noncompliance as an immediate jeopardy situation. To improve oversight efforts, CMS has provided guidance for quickly identifying and handling immediate jeopardy situations regardless of provider type in Appendix Q of the State Operations Manual. In March 2019, CMS made revisions to clarify what information is needed to identify immediate jeopardy cases across all healthcare provider types. CMS believes that this will result in quickly identifying and ultimately responding to these situations. As part of this guidance, CMS will require a standardized notification process for surveyors to follow when immediate jeopardy is identified to ensure that providers, suppliers, or laboratories are notified as soon as possible of an immediate jeopardy finding. This process is intended to increase transparency, and improve timeliness and clarity of communication to providers, suppliers, and laboratories.
CMS will continue to diligently perform our survey and certification efforts to ensure that all hospices meet the applicable conditions of participation in the Medicare and/or Medicaid programs and we are also working to strengthen our oversight efforts to prevent and address harm.

OIG's recommendations and CMS' responses are below.

OIG Recommendation
Strengthen requirements for hospices to report abuse, neglect, and other harm.

CMS Response
CMS concurs with this recommendation. Hospices are required under 42 CFR 418.52(b)(4) to ensure that verified violations are reported to state and local bodies having jurisdiction (including to the state survey and certification agency). CMS will review our interpretive guidance for opportunities to clarify existing guidance on reporting these violations.

OIG Recommendation
Ensure that hospices are educating their staff to recognize signs of abuse, neglect, and other harm.

CMS Response
CMS concurs with this recommendation. CMS will continue to provide educational materials that hospices can use when training their employees through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters as well as through the Hospice Open Door Forum and the Integrated Surveyor Training Website.

OIG Recommendation
Strengthen guidance for surveyors to report crimes to local law enforcement.

CMS Response
CMS concurs with this recommendation. CMS will look into ways to strengthen guidance for surveyors to report suspected crimes to law enforcement within CMS' current regulatory authority.

OIG Recommendation
Monitor surveyors' use of immediate jeopardy citations.

CMS Response
CMS concurs with this recommendation. CMS will monitor surveyors' use of immediate jeopardy in hospices for State agencies. As stated above, in March 2019, CMS made revisions to the State Operations Manual to clarify what information is needed to identify immediate jeopardy cases across all healthcare provider types. CMS believes that this will result in quickly identifying and ultimately responding to these situations. As part of this guidance, CMS will require a standardized notification process for surveyors to follow when immediate jeopardy is identified to ensure that providers, suppliers, or laboratories are notified as soon as possible of an immediate jeopardy finding. This process is intended to increase transparency, and improve timeliness and clarity of communication to providers, suppliers, and laboratories.

OIG Recommendation
Improve and make user-friendly the process for beneficiaries and caregivers to make complaints.

CMS Response
CMS partially concurs with this recommendation. CMS shares the OIG's goal of improving the complaint process for hospice beneficiaries and caregivers, and we will look into ways to improve the complaint making process for beneficiaries and caregivers, however, these improvements will need to be done within regulatory constraints and with available resources. For example, we will review the information contained in our existing educational materials, such as the Hospice Handbook[2], to see if it should be updated to be more user-friendly.

[2] https://www.medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF

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This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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