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Report to Congressional Committees

May 2024

MEDICARE HOSPICE

CMS Needs to Fully Implement Statutory Provisions and Prioritize Certain Overdue Surveys

GAO-24-106442

GAO Highlights

Highlights of GAO-24-106442, a report to congressional committees

May 2024

MEDICARE HOSPICE

CMS Needs to Fully Implement Statutory Provisions and Prioritize Certain Overdue Surveys

Why GAO Did This Study

In fiscal year 2022, over 1.7 million Medicare beneficiaries received hospice care. GAO and the Department of Health and Human Services' (HHS) Office of Inspector General have reported on the need to strengthen oversight to protect Medicare beneficiaries receiving hospice services.

The CAA included a provision for GAO to report on hospice quality of care and CMS's oversight of such care. This report addresses, among other things, CMS's implementation of hospice-related CAA provisions; the extent to which hospices were cited for serious quality deficiencies from 2017 through 2022; and the number of hospices with overdue surveys, and CMS's efforts to prioritize survey administration.

GAO reviewed CMS documentation and interviewed CMS officials, provider and consumer groups, and surveyors. GAO also analyzed CMS data on hospice surveys from 2017 through 2022 for hospices that had at least one standard survey in each of the two 3-year reporting cycles during this time. To count the number of hospices with overdue surveys, GAO reviewed data provided by CMS as of May 2023.

What GAO Recommends

GAO is making four recommendations to CMS, including that the agency fully implement the remaining three CAA provisions, and prioritize completion of standard surveys for those hospices that are overdue based on potential risk factors. HHS agreed with three recommendations, but disagreed with prioritizing survey completion based on risk factors. GAO continues to believe this recommendation is warranted.

View GAO-24-106442. For more information, contact Leslie V. Gordon at (202) 512-7114 or gordonlv@gao.gov.

What GAO Found

Federal law defines the quality standards that hospices must meet to participate in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) monitors compliance with these standards through inspections—referred to as standard surveys—to be carried out at least every 3 years. Serious quality deficiencies cited on a survey indicate the hospice may not have the capacity to furnish adequate care or may adversely affect the health and safety of patients.

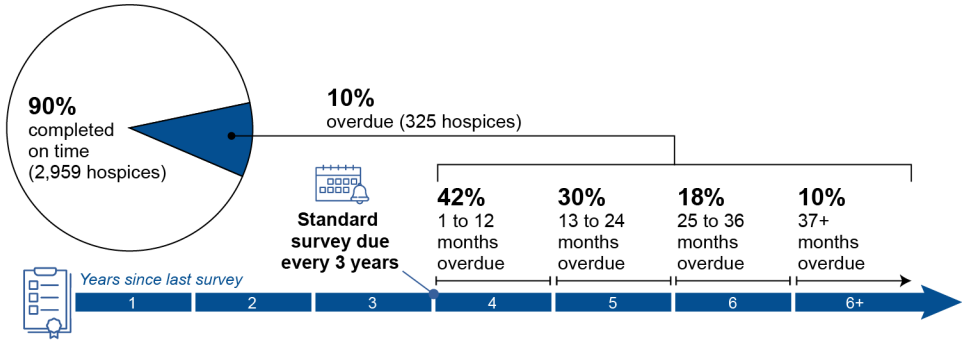
CMS has fully implemented five and partially implemented three of the eight provisions related to hospice oversight required through the Consolidated Appropriations Act, 2021 (CAA). For example, CMS has not issued planned internal guidance that would enable consistent use of new enforcement tools for hospices not complying with quality standards. Implementing these provisions would help ensure CMS meets its statutory obligations for hospice oversight.

GAO also found that about 15 percent of hospices that had at least one standard survey in each 3-year reporting cycle between 2017 and 2022 were cited with serious quality deficiencies, and most were cited with multiple such deficiencies. CMS policy requires that these hospices undergo additional monitoring and face termination from the Medicare program without timely resolution; according to CMS officials, 18 hospices were terminated between 2017 and 2022.

As of May 2023, about 10 percent of hospices participating in Medicare for 36 months or more were overdue for a survey. Of the hospices with overdue surveys, over one quarter had not had a standard survey in at least 5 years. In addition, 17 percent had at least one previous serious quality deficiency, and about 11 percent had a previous complaint that was severe and substantiated. CMS defines survey priorities each year, but does not provide any direction to prioritize among overdue surveys. CMS has noted that funding and staffing issues at state agencies, which conduct the surveys, as well as the COVID-19 public health emergency, have constrained the timely completion of surveys. Prioritizing among overdue standard surveys for hospices based on potential risk factors, such as previous quality issues, could help target such hospices.

Hospices with Overdue Surveys, by the Length of Time Overdue, as of May 2023

Of 3,284 hospices that had been enrolled in Medicare for at least 36 months at the end of May 2023:



Source: GAO analysis of Centers for Medicare & Medicaid Services data; keenan/stock.adobe.com (icons). | GAO-24-106442

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Abbreviations

AO	accrediting organization
CAA	Consolidated Appropriations Act, 2021
CLD	condition-level deficiency
CMS	Centers for Medicare & Medicaid Services
HHS-OIG	Department of Health and Human Services' Office of Inspector General
SA	state survey agency
SSC	substantiated severe complaint

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Congressional Committees

In fiscal year 2022, over 1.7 million Medicare beneficiaries received hospice care, totaling about $23 billion in Medicare spending.[1] Hospice services address the physical and emotional needs of beneficiaries at the end of their lives—with a life expectancy of 6 months or less—and often allow beneficiaries to receive the care they need from home. Federal law defines the quality standards that hospices must meet to participate in the Medicare program.[2] The Centers for Medicare & Medicaid Services (CMS) monitors compliance with these standards through inspections—referred to as standard surveys. These surveys are to be carried out at least once every 3 years.

In the last 5 years, the Department of Health and Human Services' Office of Inspector General (HHS-OIG) and we have recommended several actions to strengthen oversight and better protect Medicare beneficiaries receiving hospice services. For example, the HHS-OIG found that in surveys conducted from 2012 through 2016, over 80 percent of hospices had at least one deficiency in the quality of care they provided.[3] The HHS-OIG's report made several recommendations to CMS, including that the agency increase its oversight of hospices with a history of serious quality deficiencies. Serious quality deficiencies indicate the hospice may not have the capacity to furnish adequate care or may adversely affect the health and safety of patients. CMS concurred with this recommendation, but expressed concern that the agency may not have adequate resources to increase the frequency of its standard surveys, and that the agency already had procedures in place to identify and address these hospices. In addition, in 2019, we found that CMS had limited tools to address noncompliance with quality standards and

[1]Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements, 88 Fed. Reg. 20,022, 20,027 (Apr. 4, 2023).

[2]See 42 C.F.R. §§ 418.52 *et seq*. (2023).

[3]See Department of Health and Human Services, Office of Inspector General, *Hospice Deficiencies Pose Risks to Medicare Beneficiaries*, OEI-02-17-00020 (July 2019). See also 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).

recommended that Congress consider giving CMS greater authority to address such noncompliance.[4]

Subsequent to these reports, Congress passed and the President signed into law the Consolidated Appropriations Act, 2021 (CAA), which addressed our recommendation and included several provisions specific to oversight of hospice services under the Medicare program, as well as some additional funding to carry out those provisions.[5] For example, the CAA provided CMS authority to implement enforcement actions for hospices that fall out of compliance with quality standards.

The CAA also included a provision for us to examine CMS's application of the new enforcement actions, including the quality of care provided to Medicare beneficiaries. In this report, we

1. examine the extent to which CMS has implemented the hospice-related CAA provisions;
2. describe the extent to which hospices were cited for serious quality deficiencies in surveys from 2017 through 2022, and CMS efforts to monitor hospices with serious quality deficiencies;
3. describe the number of hospices with overdue surveys as of May 2023, and examine CMS's efforts to prioritize survey administration; and
4. describe stakeholder perspectives on factors that may affect Medicare beneficiaries' access to hospice care, and CMS efforts to improve access.

To examine CMS efforts to implement the hospice-related CAA provisions, we reviewed relevant CMS documentation, including proposed and final rules that implemented various CAA provisions. For reporting purposes, we grouped hospice-related CAA provisions into four

[4]See GAO, *Medicare Hospice Care: Opportunities Exist to Strengthen CMS Oversight of Hospice Providers*, GAO-20-10 (Washington, D.C.: Oct. 18, 2019). In 2022, we also reported gaps in CMS's requirements for reporting abuse and neglect allegations in hospices and recommended that CMS require the immediate reporting of all such allegations to the appropriate authorities, even if the perpetrator is not affiliated with the hospice. As of February 2024, CMS had not yet addressed the recommendation. See GAO, *Abuse and Neglect: CMS Should Strengthen Reporting Requirements to Better Protect Individuals Receiving Hospice Care*, GAO-23-105463 (Washington, D.C.: Dec. 12, 2022).

[5]Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, § 407, 134 Stat. 1182, 3003 (2020) (codified at 42 U.S.C. § 1395i-6).

categories: complaint hotlines, enforcement, survey transparency, and survey consistency. In addition, we interviewed CMS officials to obtain information on progress in implementing the hospice provisions. We also interviewed a set of six researchers and 15 stakeholder groups—including five consumer advocacy groups, five provider groups, and five survey entities—to obtain their perspectives on CMS's efforts to implement provisions of the CAA. We selected these researchers and stakeholder groups based on involvement in or knowledge of hospice care, or their work advocating for hospice beneficiaries and their families or caretakers.[6] The views of those researchers and stakeholder groups we selected are not generalizable to all such groups, but they provided valuable insights on CMS oversight efforts for hospices and factors that affect access to care, among other things.

To describe the extent to which hospices were cited for serious quality deficiencies in surveys from 2017 through 2022, we analyzed CMS's survey data. These were the most recent complete years of data available when we began our analysis. We included in our analyses 6,622 hospices that billed Medicare any time from 2017 through 2022. For the 4,203 hospices with at least one standard survey in each of the two 3-year reporting cycles in our study time frame (2017 through 2019 and 2020 through 2022), we counted the number and share of hospices that had serious quality deficiencies.[7] Because the population of hospices included in this analysis is limited to those hospices with at least one standard survey in each 3-year reporting cycle, inferences cannot be drawn about all hospices enrolled in Medicare between 2017 and 2022. We also analyzed CMS data on hospice complaints to count the number and share of hospices with substantiated severe complaints (SSC),

[6]The survey entities we spoke with included state survey agency (SA) officials from Michigan and Texas. We selected these states to achieve variation in their geographic region and the number of hospices in the state, among other factors. We also spoke with representatives from the three hospice accrediting organizations (AO) that conduct some hospice surveys: Accreditation Commission for Health Care, Inc., Community Health Accreditation Partner, and The Joint Commission. Consumer advocacy groups included the Center for Medicare Advocacy; the Michigan and Texas Office of the Long-term Care Ombudsman; and the two Beneficiary and Family-Centered Care Quality Improvement Organizations that contract with CMS to review complaints and help improve quality of care for Medicare beneficiaries, Kepro and Livanta. Provider groups included the American Geriatrics Society; Hospice and Palliative Nurses Association; LeadingAge; National Association for Home Care & Hospice; and the National Hospice and Palliative Care Organization. In this report we sometimes generally refer to these groups and researchers collectively as "stakeholders."

[7]For the 15 percent (614) of hospices that had more than one standard survey in either cycle, we randomly selected one to be included in our analysis.

another indicator of noncompliance with hospice quality standards. We defined SSCs as complaints that were assigned to either of the two most concerning severity levels by CMS and substantiated via an investigation. Because complaints can be filed against a hospice at any point outside of the standard survey process, we counted SSCs across the entire 6-year period for all 6,622 hospices in our review.

To describe CMS efforts to monitor hospices with serious quality deficiencies, we reviewed relevant CMS documentation, including the state operations manual.[8] We also interviewed CMS officials about efforts the agency had for following up on hospices with serious quality deficiencies.[9]

To describe the number of hospices with overdue surveys as of May 2023, we reviewed data provided by CMS for 3,284 hospices that had been enrolled in Medicare for at least 36 months as of May 2023.[10] These data included the dates on which the most recent standard surveys were performed for these hospices. We analyzed these data to determine the number of hospices with overdue standard surveys at that time (i.e., hospices that had not received a standard survey during the 37 months prior to the end of May 2023) and the amount of time that had passed since each hospice's last standard survey. We also used these data to identify the number of hospices with overdue surveys by state. To examine CMS's efforts to prioritize survey administration, we reviewed relevant CMS documentation, including the agency's annual Mission and

[8]The CMS State Operations Manual provides CMS policy regarding survey and certification activities for hospice providers. See Centers for Medicare & Medicaid Services, "Appendix M - Guidance to Surveyors: Hospice," *State Operations Manual* (Revision 210) (Baltimore, Md.: Feb. 3, 2023).

[9]We did not independently verify the extent to which existing efforts were implemented for all hospices with serious quality deficiencies.

[10]These data came from the same CMS survey databases that we used to identify hospices with serious quality deficiencies; however, for this analysis, CMS provided us with a custom data file that allowed us to identify hospices that were overdue for standard surveys. Based on CMS guidance regarding the potential lag between the completion of surveys and the uploading of results to the survey database, we identified May 30, 2023, as the most recent date on which standard survey data for hospices were reasonably complete at the time of our analysis. Using the most recent survey data for this analysis also allowed more time for surveyors to address the potential impact of the COVID-19 public health emergency on standard survey timeliness.

We included only hospices that had been enrolled in Medicare for at least 36 months in this analysis because these hospices should have all had at least one standard survey beyond their initial enrollment surveys.

Priorities documents, and interviewed CMS officials. In addition, we evaluated CMS's efforts to prioritize survey administration against selected federal internal control standards.[11]

To assess the reliability of survey and complaint data, and CMS's data on the most recent standard surveys, we examined relevant documentation, interviewed knowledgeable agency officials, conducted simple data checks, and took steps to clean the data, as appropriate. We determined that these data were sufficiently reliable for the purpose of our objective. (See app. I for additional details on the scope and methodology of this data analysis, including limitations.)

To describe stakeholder perspectives on factors that may affect Medicare beneficiaries' access to hospice care and CMS efforts to improve access, we obtained perspectives of representatives from the six researchers and 15 stakeholder groups, described above. We also interviewed CMS officials and reviewed CMS documentation.

We conducted this performance audit from December 2022 to May 2024 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicare Hospice Benefit

According to CMS, the goal of hospice care is to help terminally ill individuals live as normal lives as possible while remaining primarily in their home environment.[12] In order to be eligible for the Medicare hospice benefit, beneficiaries must be certified as having a terminal illness with a

[11]See GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's management, oversight body, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. We determined that risk assessment was significant to our objectives, as well as the underlying principle that management should identify, analyze, and respond to risks. We also determined that the design of control activities to achieve objectives and respond to risks was significant to our objectives.

[12]This care is most often provided in private homes, but can also be provided in freestanding hospice facilities, hospitals, nursing homes, or other settings.

life expectancy of 6 months or less if the illness runs its normal course.[13] While originally the hospice benefit largely served beneficiaries with cancer diagnoses, beneficiaries can enter into hospice with a wide range of terminal illnesses, including cancer, kidney failure, heart disease, and dementia.

- **Services provided.** The Medicare hospice benefit covers a variety of services and supplies for the palliation and management of the terminal illness, including physician and nursing services; medical equipment and supplies, including drugs for pain and symptom management; hospice aide and homemaker services; physical and occupational therapy; and spiritual, and grief and loss counseling. A hospice interdisciplinary team (in collaboration with the beneficiary's primary care provider, if any) works with the beneficiary, family, and caregivers to develop a plan of care that addresses the physical, psychosocial, spiritual, and emotional needs of the beneficiary, family members, and caregivers. The hospice provider must make all services under the Medicare hospice benefit available to beneficiaries as needed, 24 hours a day, 7 days a week.
- **Forfeiture of curative care.** Enrolling in the hospice benefit is a beneficiary's choice and when doing so, the beneficiary must sign a statement indicating they are waiving their rights to Medicare payment for services related to curative treatment of their terminal illness. Medicare will, however, continue to pay for curative treatment of conditions that are not related to the terminal illness. This could include, for example, dialysis treatment for patients with kidney disease for whom a 6-month prognosis is related to another condition.

Federal Oversight of Hospice Providers Participating in Medicare

Federal law requires that hospices continuously meet certain quality standards—designed to ensure the health and safety of hospice beneficiaries—in order to participate in the Medicare program.[14] These quality standards are described in the Medicare Conditions of Participation.

[13]42 U.S.C. § 1395x(dd)(3)(A); 42 C.F.R. § 418.22(b) (2023).

[14]See 42 C.F.R. §§ 418.52 *et seq*. (2023).

Accrediting Organizations (AO)

In addition to partnering with state survey agencies (SA), the Centers for Medicare & Medicaid Services (CMS) has approved three AOs to carry out some hospice surveys. CMS-approved AOs must demonstrate that their health and safety requirements and survey and oversight processes meet or exceed those used by SAs to determine provider compliance with quality standards. AOs can provide Medicare certification services, as well as other accreditation services to hospices for a fee. Hospices choose whether to obtain Medicare certification through SAs or through AOs.

Source: GAO analysis of CMS documentation. | GAO-24-106442

CMS partners with state survey agencies (SA) and national private accrediting organizations (AO) to oversee compliance with these standards for Medicare providers, including hospices.[15] Upon the enrollment of a hospice in the Medicare program and at least every 3 years thereafter, an SA or CMS-approved AO completes a standard survey. As a part of the survey, SAs and AOs select a sample of patients and gather information on the extent to which each hospice complies with quality standards through the care provided to those patients. In addition, when consumers (beneficiaries or their caregivers) have a concern about the quality of care that was provided in a hospice, they can submit a complaint through an SA or AO, which will examine the complaint and may conduct a special complaint investigation.[16]

If the SA or AO—through a standard survey or a complaint investigation—finds that a hospice is out of compliance with Medicare's quality standards, the SA or AO cites the hospice with one of two types of deficiencies: condition-level deficiencies (CLD)–referred to in this report as serious quality deficiencies–or standard-level deficiencies.

Condition-level deficiency. This type of deficiency is the most serious. A CLD is one in which the provider violates one or more standards, and the deficiencies are of such character as to substantially limit the provider's capacity to furnish adequate care or which adversely affect the health and safety of patients. For example, one quality standard outlines that hospice providers must conduct and document an initial, patient-specific comprehensive assessment of the patient's physical, emotional, and spiritual care needs, among other things.[17] Under this standard, hospices could be cited for a CLD if they fail to make timely or comprehensive assessments, as required. When a hospice provider is cited for a CLD, CMS places the provider on a 90-day termination track within which the provider must correct the deficiency and the correction must be confirmed

[15]For example, SAs also help oversee compliance for nursing homes that participate in the Medicare program. AOs help oversee compliance only for certain provider types, such as hospices, home health agencies, and hospitals.

[16]Consumers can also file complaints through CMS-contracted Beneficiary and Family Centered Care Quality Improvement Organizations, which can help mediate consumer concerns and assist with beneficiary appeals. In addition, consumers in long-term care settings, such as nursing homes, can file complaints through state long-term care ombudsman programs.

[17]42 C.F.R. § 418.54 (2023).

via a follow-up survey visit.[18] If this does not happen within 90 days of the survey date, CMS can terminate the hospice's Medicare provider agreement.[19]

Serious quality deficiencies can be further categorized as immediate jeopardy, which indicates that the hospice's noncompliance has placed or is likely to place the health and safety of its patients at risk for serious injury, harm, impairment, or death. For example, one or more serious deficiencies could result in immediate jeopardy. CMS places providers with an immediate jeopardy deficiency on a 23-day termination track.[20]

Standard-level deficiency. This type of deficiency is less serious. A hospice provider that has a standard-level deficiency is required to submit to CMS an acceptable plan of correction for achieving compliance within a reasonable period of time. According to CMS officials, if a provider fails to submit or implement a plan of correction within a period of time acceptable to CMS, the provider is placed on a 90-day termination track.

Oversight of State Survey Agencies and Accrediting Organizations

CMS oversees the SA and AO surveyors in various ways.

- **State survey agency oversight.** Through the State Performance Standards System program, CMS conducts annual performance assessments of SAs across Medicare provider types, including hospices. As a part of the annual performance assessment, CMS selects measures each year that it uses to determine how well states' SAs are ensuring that Medicare providers meet quality standards. For example, some states have faced challenges completing hospice surveys in a timely fashion; CMS identified several states that did not meet timeliness standards in at least one instance from fiscal year 2017 through fiscal year 2019.[21] CMS continues to track the

[18]See Centers for Medicare & Medicaid Services, "Chapter 3 – Additional Program Activities," *State Operations Manual* (Revision 202) (Baltimore, Md.: June 19, 2020) (§ 3012).

[19]When hospices are terminated from the Medicare program, they are no longer eligible to receive payment for services provided to Medicare beneficiaries. Prior to the CAA, the 90-day termination track was the only enforcement action available to CMS.

[20]See Centers for Medicare & Medicaid Services, "Chapter 3 – Additional Program Activities," *State Operations Manual* (Revision 202) (Baltimore, Md.: June 19, 2020) (§ 3010).

[21]See Centers for Medicare & Medicaid Services, *Fiscal Year (FY) 2020 State Performance Standards System (SPSS) Findings, FY 2021 SPSS Guidance, and FY 2019 Results*, 21-08-ALL (Baltimore, Md.: Sept. 15, 2021).

timeliness of surveys; for fiscal year 2023, CMS assessed the extent to which SAs reduced the number of overdue standard surveys and complaint investigations.[22] The results of these performance assessments are summarized and published for SAs annually.

- **Accrediting organization oversight.** CMS also conducts what are known as validation surveys for a sample of AO-surveyed hospices. Historically, an SA conducted a survey 60 days after an AO survey, and CMS compared the serious quality deficiencies cited by the SA with all deficiencies cited by the AO. This analysis was reported as a disparity rate between SA and AO findings in CMS's annual report to Congress on AO performance. Beginning in fiscal year 2024, CMS contractors will directly observe AO surveyors for validation surveys.[23]

CMS is also responsible for directing the priorities that SAs take into account when determining which hospices to survey. For example, CMS specifies four priority tiers for each Medicare provider type, including hospice providers, that states use in planning how they carry out their survey workloads.[24] In addition, CMS officials oversee the recommendations of SAs and AOs, and make the final determination in decisions, such as enforcement actions, which include program termination.

In response to the COVID-19 public health emergency, CMS limited survey activity to focus on the most serious health and safety threats. As such, standard surveys were suspended between March and August 2020.[25] According to CMS and provider stakeholders, the timeliness of standard surveys was also impacted by the public health emergency. In addition, validation surveys were paused in March 2020 and resumed for fiscal year 2024. At the end of January 2023, CMS implemented changes to its standard survey process, instructing SA and AO surveyors to

Medicare Quality Standards for Hospices

In 2023, the Centers for Medicare & Medicaid Services (CMS) outlined several quality standards that more specifically contribute to the understanding of the quality of care directly delivered to patients and families. Such quality standards include those related to

- patient's rights,
- initial and comprehensive assessment of the patient,
- care planning, and
- coordination of services.

The remaining quality standards included those related to

- quality assessment and performance improvement,
- volunteers, and
- the organization and administration of services.

Source: GAO analysis of CMS documentation. | GAO-24-106442

[22]See Centers for Medicare & Medicaid Services, *REVISED: Fiscal Year (FY) 2023 State Performance Standards System (SPSS) Guidance*, 23-12-ALL (Baltimore, Md.: Aug. 11, 2023). As of February 2024, results were not available for fiscal year 2023.

[23]See Centers for Medicare & Medicaid Services, *Resuming Validation of Accrediting Organization Surveys*, 23-14-NLTC (Baltimore, Md.: Sept. 6, 2023).

[24]For example, see Centers for Medicare & Medicaid Services, *Fiscal Year (FY) 2024 Mission & Priorities Document (MPD) — Action,* 24-07-ALL, (Baltimore, Md.: Dec. 13, 2023).

[25]See Centers for Medicare & Medicaid Services, *Rescinded COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control Deficiencies, and Quality Improvement Activities in Nursing* Homes, QSO-20-31-ALL (Baltimore, Md.: June 1, 2020) (Revised Jan. 4, 2021; Rescinded as of Mar. 20, 2023).

prioritize the time and attention of their review on a specific set of quality standards that contribute to understanding the quality of care delivered directly to patients, families, and caregivers.[26] In contrast, quality standards that focus more on administrative functions and operations of hospice services are a second-order priority during standard surveys.

CMS provides information on hospice providers that participate in the Medicare program through its consumer transparency tool website, Care Compare, with the stated goal of helping consumers make more informed care choices. Through this website, CMS also makes information available on hospice quality measures and other characteristics for each hospice provider.

CMS Has Not Fully Implemented Hospice Provisions, Including those Related to Enforcement and Survey Transparency

CMS has fully implemented five of the eight CAA hospice-related provisions and partially implemented the remaining three provisions. Table 1 shows the implementation status of these eight provisions, organized into four categories: complaint hotlines, enforcement, survey transparency, and survey consistency.

[26]See Centers for Medicare & Medicaid Services, "Appendix M – Guidance to Surveyors: Hospice," *State Operations Manual*, (Revision 210) (Baltimore, Md.: Feb. 3, 2023). For example, as part of the patient's initial comprehensive assessment, hospices must assess family and caregiver grief needs and provide relevant services; surveyors are directed to ensure grief planning and service provision occurred as part of the priority items.

Table 1: Centers for Medicare & Medicaid Services (CMS) Implementation of the Consolidated Appropriations Act, 2021 (CAA) Hospice Provisions as of January 2024

CAA Requirement	Status	Notes
COMPLAINT HOTLINES		
Requires states to establish a complaint hotline if they have not already done so.[a]	●	CMS officials confirmed that all states had a complaints hotline in place as of September 2023.
ENFORCEMENT		
Requires CMS to develop and implement a range of enforcement tools for noncompliant hospice programs (as well as appeals procedures).[b]	◐	CMS published a final rule in November 2021 that established new enforcement tools. CMS officials shared that training was available and internal guidance was being drafted, but as of January 2024 the guidance had not been finalized.
Requires CMS to create a special focus program (SFP) for poorly performing hospices.[c]	●	CMS issued an initial SFP proposal and convened a technical expert panel in 2022. Based on panel recommendations, CMS proposed a final SFP methodology in July 2023, which the agency finalized in November 2023, to be implemented in 2024.
SURVEY TRANSPARENCY		
Requires public reporting of the results of hospice surveys conducted by state survey agencies (SA) and accrediting organizations (AO) on the CMS website in a manner that is prominent, easily accessible, searchable, and readily understood.[b]	◐	CMS posted some survey data on its publicly available Quality, Certification, and Oversight Reports (QCOR) platform. CMS had not posted prominent, easily accessible, and readily understandable survey data on Care Compare, as planned, as of December 2023.
SURVEY CONSISTENCY		
Requires that AOs use the same survey results form as SAs.[d]	●	CMS issued guidance in October 2021 and CMS officials confirmed that all AOs were submitting the required forms as of March 2022.
Requires CMS to provide comprehensive testing and training of SA and AO surveyors, including training with respect to review of written plans of care.[d]	●	CMS issued training in January 2023 and officials confirmed that all AO surveyors and some SA surveyors had completed the training as of December 2023.
Requires SAs and AOs to use a multidisciplinary team for surveys (to include at least one registered nurse) and prohibits surveyors from surveying hospice programs for which they have worked in the last 2 years or in which they have financial interest.[d]	●	CMS issued guidance in October 2021 and federal regulations in November 2021, formally implementing these requirements.
Requires states to measure and reduce inconsistency in survey results among all surveyors.[c]	◐	CMS identified plans in November 2021 to check the findings of AO and SA surveyors, but according to CMS officials, the agency does not plan to do so for SAs as of fiscal year 2024.

● = implemented

◐ = partially implemented

Source: GAO analysis based on Centers for Medicare & Medicaid Services documentation and interviews. | GAO-24-106442

Notes:

[a]This provision was to be implemented by December 27, 2021.

[b]This provision was to be implemented by October 1, 2022.

[c]This provision was to be implemented upon enactment of the CAA.

[d]This provision was to be implemented by October 1, 2021.

Complaint hotlines. CMS implemented this provision by issuing guidance to states and monitoring the status of states' complaints hotlines. In October 2021, CMS issued guidance to states on what was expected for implementation of the hotline; as of September 2023, CMS officials confirmed that all states had complaint hotlines in place. CMS maintains complaint hotline contact information on its website, and officials told us that they conduct quarterly checks to ensure that the hotlines are functional.[27]

Several stakeholders we spoke with were generally supportive of this provision, particularly considering the need for an easy mechanism for consumers to file complaints given certain barriers to filing them. According to these stakeholders, the barriers included exhaustion in a time of crisis, and a lack of awareness on where and how to file complaints. In addition, according to some stakeholders, consumers may have a reluctance to file complaints due to a fear of how the complaint may affect care still being received. For example, consumers may fear that if they complain about the quality of care that they or a loved one has received, the hospice may terminate care.

Hospice Enforcement Tools

In 2021, the Centers for Medicare & Medicaid Services (CMS) finalized its rule for the development of additional enforcement tools for use with hospice providers. These enforcement tools included civil monetary penalties of up to $10,000 for each day of noncompliance, suspension of payments for new admissions, and the appointment of temporary management to oversee hospice operations. The preamble to the final rule outlines the circumstances under which each tool may be considered. These enforcement tools are similar to those available for use with other provider types, such as skilled nursing facilities and home health providers.

Source: GAO analysis of CMS rulemaking and documentation. | GAO-24-106442

CMS has not fully implemented CAA hospice provisions related to enforcement, survey transparency, and survey consistency.

Enforcement tools. CMS has begun developing enforcement tools—such as civil monetary penalties—to be used for noncompliance, as well as a process for appealing the enforcement tools. However, CMS had not completed implementation as of January 2024. The CAA required CMS to develop and implement a range of enforcement tools for noncompliant hospices by October 1, 2022. CMS has issued details on the new enforcement tools through rulemaking in November 2021 and made a

[27]For state complaint hotline contact information, see Centers for Medicare & Medicaid Services, *Contact Information for Filing a Complaint with the State Survey Agency*, (July 20, 2022), accessed January 17, 2024, www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Complaintcontacts.pdf. Consumers may also file complaints through Beneficiary and Family Centered Care Quality Improvement Organizations and, if they are in a long-term care setting such as a nursing home, through their state long-term care ombudsman programs.

training available to CMS staff and SA surveyors.[28] CMS officials told us that it anticipated finalizing internal guidance related to the use of the new enforcement tools in the beginning of 2024, in part, to promote consistent application of the new tools. CMS officials told us that as of January 2024 the agency had used enforcement tools three times: two payment suspensions and one civil monetary penalty. However, until CMS fully implements the new enforcement tools, including issuing its planned internal guidance, CMS will not meet its statutory obligation to address poorly performing hospices.

Special Focus Program. The Special Focus Program is a program that temporarily increases oversight for poorly performing hospices until they either improve performance or are terminated from the Medicare program. (See sidebar.) In November 2023, CMS finalized details for the Special Focus Program.[29] After convening a technical expert panel to consider implementation details, CMS outlined an algorithm to determine the top 10 percent of poorly performing hospices based on survey and other data. Based on CMS's estimate using data from 2019 through 2021, this could result in roughly 590 hospices being Special Focus Program candidates. CMS will then select Special Focus Program participants from these candidates—up to 1 percent based on available resources, according to CMS officials. The officials further noted that they will enroll 50 hospices in the first year of the program, and that CMS intends to avoid the selection of hospices that are already the subject of enforcement tools or other enhanced monitoring. CMS officials stated that the first Special Focus Program selections would take place near the end of 2024.

Selecting Hospices for the Special Focus Program

Hospices will be given a score based on results from three sources of data: survey and complaint data; claims-based quality data, as reported through the Hospice Quality Reporting Program; and caregiver experience survey data. The Centers for Medicare & Medicaid Services (CMS) will identify Special Focus Program candidates each year, defined as the top 10 percent of poorly performing hospices based on their aggregate scores across data sources. CMS will then make a selection of Special Focus Program participants from that list of candidates—estimated at up to 1 percent of hospices, according to CMS officials. Special Focus Program participants must undergo surveys every 6 months until the program is completed. The Special Focus Program is similar to a program available for use with skilled nursing facilities, but has several significant methodological differences. For example, nursing home selections are stratified by state.

Source: GAO analysis of CMS rulemaking and documentation. | GAO-24-106442

[28]Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Model Expansion; Home Health and Other Quality Reporting Program Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; and COVID–19 Reporting Requirements for Long-Term Care Facilities, 86 Fed. Reg. 62,240 (Nov. 9, 2021) (codified at 42 C.F.R. §§ 488.1200-1265 (2023)).

[29]Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements, 88 Fed. Reg. 77,676 (Nov. 13, 2023) (to be codified at 42 C.F.R. § 488.1135).

Survey transparency. CMS began implementing the CAA's survey transparency provision, but had not fully implemented it as of December 2023. Specifically, CMS posted survey information on a website that is publicly available, but that information was not prominent, easily accessible, or readily understandable, as required by the CAA.[30] CMS has stated that the survey information posted on its Quality, Certification, and Oversight Reports website is prominent and easily accessible, and readily understandable.[31] However, this information is not linked via CMS's consumer transparency tool website, Care Compare. Users of the Quality, Certification, and Oversight Reports website can search for a hospice by name, but the most recent survey results are not available through the links on the website; instead, separate links on the Quality, Certification, and Oversight Reports website provide a spreadsheet that contains rows with all deficiencies found in a limited set of surveys.

Several stakeholder groups and researchers we spoke with emphasized the importance of survey information being accessible and understandable for consumers or provided with the appropriate context. For example, one stakeholder group pointed out that the CMS survey forms can be long documents that would be difficult for consumers to sift through. Some stakeholders noted that survey information can be described in a technical nature, but plain language—as well as definitions of key terms—is important for understandability. One researcher noted the importance of providing the consumer with the context around what the survey is measuring and why.

CMS officials told us that the goal of Care Compare is to promote transparency for consumers so they can make informed care choices. Officials noted that the agency plans to eventually post survey information on Care Compare, and that they have solicited stakeholder input on how best to do so. Further, agency officials told us that CMS needs to secure a contractor sometime in 2024 to make the necessary information technology changes. As described earlier, the CAA required this provision to be implemented by October 2022. Posting hospice survey data on Care Compare in a user-friendly way would allow CMS to meet its obligation set through the CAA requirements, and would be consistent

[30]See Centers for Medicare & Medicaid Services, "Quality, Certification and Oversight Reports," accessed January 18, 2024, https://qcor.cms.gov/.

[31]See Centers for Medicare & Medicaid Services, *Fiscal Year (FY) 2024 Mission & Priorities Document*.

with the CMS-outlined goal of Care Compare: to help consumers make more informed care choices.

Survey consistency-related provisions. CMS has implemented three of the four provisions related to ensuring survey consistency across SAs and AOs. However, CMS has not fully implemented efforts to measure and reduce inconsistencies across surveyors. CMS detailed the implementation of these provisions—aimed at improving survey consistency across individual surveyors and surveyor entities—through agency rulemaking and guidance. The CAA required states to measure and reduce inconsistency in survey results among all surveyors upon enactment. CMS detailed its initial plans, through the rulemaking process, to measure and reduce inconsistencies across surveyors; however, as of January 2024, the agency had not carried out those plans.[32]

In September 2023, CMS officials told us they were conducting analyses to inform implementation. In January 2024, CMS officials told us they planned to continuously examine ways to improve consistency and shared plans to develop annual "focus area" trainings for all surveyors, covering areas identified as needing enhanced training or correction to improve accuracy and consistency in the survey process. In addition, in February 2024, CMS issued a proposed rule aimed at strengthening the oversight of all AOs, including AOs for hospices.[33] However, for calendar year 2024, CMS officials told us that they did not intend to fully undertake the plans previously outlined in rulemaking to address this provision; specifically, they do not intend to measure consistency for SAs. Without fully implementing this provision by measuring the consistency of SAs as it does for AOs the agency will not fully meet its mandated obligation to ensure that hospice compliance with quality standards is being consistently assessed.

Several stakeholders we spoke with acknowledged the variation in survey processes that can exist across the AO and SA surveyors—and CMS

[32]86 Fed. Reg. at 62,371. Specifically, in the preamble to the final rule for hospice survey and enforcement requirements, CMS outlined plans to require SAs to review AO survey findings, and CMS to review SA survey findings, for missed severe deficiencies per survey in order to establish a calculation of disparity rates. CMS would notify each survey entity of its disparity rate annually; a disparity rate above 10 percent in two consecutive years would trigger an agency intervention, such as additional training.

[33]Medicare Program; Strengthening Oversight of Accrediting Organizations (AOs) and Preventing AO Conflict of Interest, and Related Provisions, 89 Fed. Reg. 11,996 (Feb. 15, 2024).

data align with some of these views. Some stakeholders shared the perception that AO surveyors were more lenient than SA surveyors. This is consistent with data from previous CMS efforts to assess the reliability of AO survey findings. Specifically, CMS has historically identified the disparity rate (number of missed serious quality deficiencies, per survey) for a sample of AO surveys. For fiscal year 2020, CMS found the disparity rate between AO and SA survey findings was 20 percent.[34]

Three stakeholders noted that there can be conflicts of interest for the AO role; one stakeholder mentioned the financial conflict of being paid directly by the hospice to conduct the survey.[35] Three stakeholders reported that SA surveys lacked a collaborative or educational component, as well as familiarity with the hospice setting, when compared with AO surveyors. Two stakeholders also noted that variation can exist within surveyor entities, underscoring the importance of the CAA's consistency provisions.

About 15 Percent of Hospices Had Serious Quality Deficiencies in Each 3-Year Reporting Cycle Between 2017 and 2022

About 15 percent of the hospices we reviewed had at least one serious quality deficiency on a standard survey in each 3-year survey reporting cycle from 2017 through 2022 (about 15 percent in 2017 through 2019, and about 11 percent during the most recent cycle, 2020 through 2022). Most of these hospices also had multiple serious quality deficiencies, serious quality deficiencies that indicated a significant risk of patient harm, or the same serious quality deficiencies across multiple surveys. CMS provides additional monitoring to these hospices and certain CAA provisions will allow CMS to further increase this monitoring.

[34]See Centers for Medicare & Medicaid Services, *Report to Congress: Fiscal Year 2021 Review of Medicare's Program for Oversight of Accrediting Organizations and the Clinical Laboratory Improvement Validation Program* (Baltimore, Md.: May 2023).

[35]In the preamble to the agency's February 2024 proposed rule, CMS acknowledged that AOs have historically been allowed to provide fee-based consulting to Medicare providers, in addition to providing Medicare surveys for those same providers. CMS noted concern about perceived or actual conflicts of interest under such arrangements and proposed a prohibition on AO fee-based consulting prior to a provider's initial standard survey; within 12 months of a subsequent standard survey; or in response to a complaint investigation when the AO is responsible for surveys for that provider. The proposed rule also included a prohibition against owners, surveyors, and other employees participating in surveys of health care providers in which they have an interest or a relationship, as well as penalties for violations of conflict-of-interest provisions, among other things.

Most Hospices with a Serious Quality Deficiency Had More Than One

Of the 4,203 hospices that had at least one standard survey in each of the two 3-year survey reporting cycles,[36]

- 617 (15 percent) had serious quality deficiencies in the first 3-year reporting cycle (2017 through 2019),[37] and
- 483 (11 percent) had serious quality deficiencies in the most recent 3-year reporting cycle (2020 through 2022).[38]

In addition, 119 hospices (3 percent) had serious quality deficiencies in both 2017 through 2019 and 2020 through 2022. (See fig. 1.) Most of these hospices (83) also had the same serious quality deficiency in both reporting cycles.

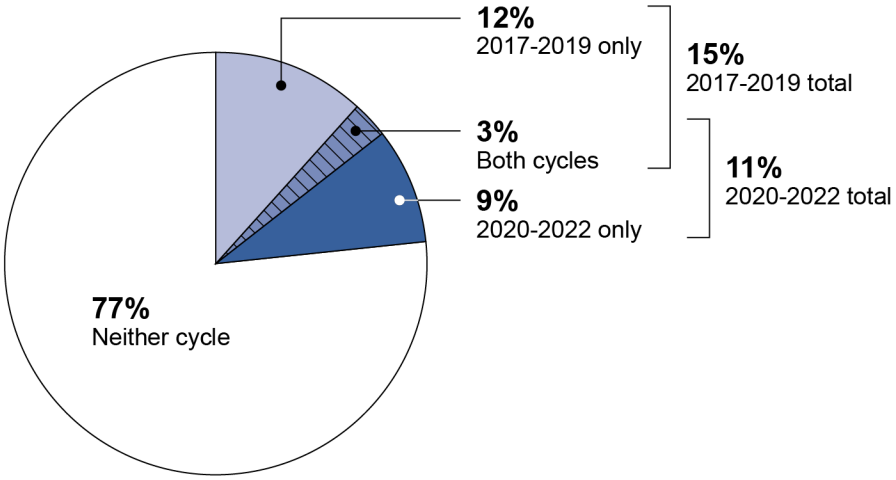
[36]Hospices receive standard surveys from CMS on rolling 3-year cycles. Because our study period included 6 years of data, we broke those years into two 3-year reporting cycles and isolated to hospices with at least one standard survey in each cycle to count deficiencies. Factors including the COVID-19 pandemic likely impacted the consistency and completion of standard surveys across cycles. For more information, see appendix I.

Of the 2,106 hospices that had at least one standard survey in only one of the 3-year cycles, 167 had serious quality deficiencies.

[37]For our analysis, serious quality deficiencies include all condition-level deficiencies cited at hospices and are not limited to those associated with the quality-focused Conditions of Participation recently identified by CMS.

[38]Because the population of hospices included in our analysis is limited to those hospices with at least one standard survey in each 3-year reporting cycle, comparisons cannot be made across the two cycles.

Figure 1: Hospices with Serious Quality Deficiencies on Standard Surveys, Cycles 2017–2019 and 2020–2022



Total = 4,203

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-24-106442

Notes: This includes hospices with at least one standard survey in each 3-year reporting cycle in our analysis: 2017 through 2019, and 2020 through 2022 (n = 4,203). About 15 percent of these hospices (617) had more than one standard survey in one or both 3-year cycles. To address the unequal numbers of standard surveys, we randomly selected a survey from each 3-year reporting cycle for hospices with more than one. Because having more than one standard survey in a given reporting cycle would have provided a greater opportunity for a hospice to receive a serious quality deficiency, we only included deficiencies from the randomly selected surveys in those cases. In these cases, randomization results in a conservative count and our analysis may understate the true extent of serious quality deficiencies. Furthermore, factors including the COVID-19 pandemic may have impacted the consistency of standard surveys across reporting cycles. As a result, comparing counts across the two 3-year reporting cycles may not be appropriate. Finally, the percentages for "2020-2022 only" and "Both cycles" do not sum to the percentage for "2020-2022 total" due to rounding.

In both reporting cycles, the vast majority of hospices with a serious quality deficiency had more than one. For example, in the most recent reporting cycle, 178 (37 percent) had between two and four serious quality deficiencies, and 240 (50 percent) had five or more. (See table 2.) Furthermore, a subset of hospices—including 25 (5 percent) in the most recent reporting cycle and eight (1 percent) in the first reporting cycle—had immediate jeopardy deficiencies that placed or were likely to have placed beneficiaries at serious risk of injury, harm, impairment, or death.

Table 2: Hospices with One or Multiple Serious Quality Deficiencies on Standard Surveys, 2017–2019 and 2020–2022

	Percent	
	2017–2019	2020–2022
Hospices with one serious quality deficiency	14	13
Hospices with 2 to 4 serious quality deficiencies	40	37
Hospices with 5+ serious quality deficiencies	46	50

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-24-106442

Notes: This includes hospices with at least one standard survey in each 3-year reporting cycle that had a serious quality deficiency during the first reporting cycle (2017-2019; n = 617) or the second reporting cycle (2020-2022; n = 483). About 15 percent of hospices with at least one standard survey in each cycle (614) had more than one standard survey in one or both 3-year time reporting cycles. To address the unequal numbers of standard surveys, we randomly selected a survey from each 3-year reporting cycle for hospices with more than one. Because having more than one standard survey in a given reporting cycle would have provided a greater opportunity for a hospice to receive a serious quality deficiency, we only included deficiencies from the randomly selected surveys in those cases. In these cases, randomization results in a conservative count and our analysis may understate the true extent of serious quality deficiencies. Furthermore, factors including the COVID-19 pandemic may have impacted the consistency of standard surveys across reporting cycles. As a result, comparing counts across the two 3-year reporting cycles may not be appropriate.

Serious quality deficiencies were most commonly cited in the following quality standards:

- **Interdisciplinary group, care planning, and coordination of services.** Hospices must designate an interdisciplinary group that, in consultation with the patient's attending physician, must prepare a written plan of care for each patient. The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment, because such needs relate to the terminal illness and related conditions.[39]
- **Organization and administration of services.** Hospices must organize, manage, and administer their resources to provide the hospice care and services to patients, caregivers, and families necessary for the palliation and management of terminal illness and related conditions.[40]
- **Initial and comprehensive assessment of the patient.** Hospices must conduct and document in writing patient-specific comprehensive assessments that identify the patient's need for hospice care and

[39]See 42 C.F.R. § 418.56 (2023).

[40]See 42 C.F.R. § 418.100 (2023).

services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment must include all areas of hospice care related to the palliation and management of the terminal illness and related conditions.[41]

Of the approximately 6,600 hospices billing Medicare at any point from 2017 through 2022, 740 (11 percent) had at least one substantiated severe complaint (SSC). About one-quarter of these hospices (181) had multiple SSCs during this time.[42] The most frequently cited SSCs included those related to quality of care or treatment, patient rights, and nursing services.

Some hospices with SSCs also had been cited with serious quality deficiencies on standard surveys that occurred between 2017 and 2022. Specifically, 157 hospices (21 percent of those with SSCs) had one or more serious quality deficiencies identified through standard surveys performed between 2017 and 2022, in addition to the SSCs.[43]

Centers for Medicare & Medicaid Services (CMS) Complaint Categories

CMS directs state survey agencies to assign complaints—or allegations of noncompliance with one or more of the hospice Conditions of Participation—to one of the following severity categories:

- Immediate jeopardy: assigned if the alleged noncompliance indicates there was serious injury, harm, impairment, or death of a patient, or the likelihood for such, and there continues to be an immediate risk of serious injury, harm, impairment, or death of a patient unless immediate corrective action is taken.
- Non-immediate jeopardy—high priority: assigned if the alleged noncompliance would not represent an immediate jeopardy deficiency, but would result in a determination of substantial noncompliance (i.e., at least one severe quality deficiency).
- Non-immediate jeopardy—medium priority: assigned if the alleged noncompliance is limited in manner and degree and/or caused, or may cause, harm that is of limited consequence.
- Non-immediate jeopardy—low priority: assigned if the alleged noncompliance may have caused physical, mental or psychosocial discomfort that does not constitute injury or damage.

Source: GAO analysis of State Operations Manual, chapter 5. | GAO-24-106442

CMS Has Efforts Under Way to Follow-Up on Hospices' Serious Quality Deficiencies

CMS provides additional monitoring to hospices with serious quality deficiencies via the 90-day termination track and to certain hospices with SSCs via the complaints enforcement track. CMS expects to further increase its monitoring of these hospices through CAA provisions related to the Special Focus Program and new enforcement tools.

[41]See 42 C.F.R. § 418.54 (2023).

[42]Complaints may be recorded twice if both the SA and AO conduct separate investigations. See appendix I for a discussion of how we managed these data and removed likely duplicates.

[43]For these hospices, the complaint may not have been related to the serious quality deficiencies.

- **Ninety-day termination track.** CMS policy requires that hospices with serious quality deficiencies be put on an enforcement track. When on this track, hospice staff are required to document their actions to address the deficiencies through a plan of correction. After CMS receives the plan of correction, surveyors must conduct an on-site follow-up visit to confirm that the deficiencies are reasonably corrected within 90 days.[44] If they are not, the hospice may be terminated from the Medicare program. CMS told us that the 981 hospices that had at least one serious quality deficiency between 2017 and 2022 would be subject to the enforcement track and receive follow-up surveys.[45] CMS officials reported that they terminated 18 hospices that were unable to correct serious quality deficiencies in a timely manner between 2017 and 2022.
- **Complaints enforcement track.** CMS officials told us that certain hospices with SSCs should be put on a separate enforcement track and given a subsequent standard survey sooner than would otherwise be required through the standard survey process. As noted previously, we found that 740 hospices had at least one SSC between 2017 and 2022.
- **Special Focus Program**. As previously discussed, in accordance with the CAA, CMS has implemented the Special Focus Program for hospices with serious quality deficiencies. The program stipulates that CMS will increase monitoring for participating hospices by conducting surveys at least every 6 months. Without evidence of improvement on these surveys, Special Focus Program participants will be considered for termination from the Medicare program. According to CMS officials, the Special Focus Program is likely to capture up to 1 percent of all hospices, based on available resources, and will not include hospices that are on an enforcement track when program participants are selected.
- **New enforcement tools.** The CAA gave CMS the authority to use new enforcement tools—including civil monetary penalties, payment suspensions for new admissions, and the appointment of temporary management to oversee hospice operations—to incentivize hospices to regain compliance with quality standards. As previously discussed,

[44]In these instances, hospices that were receiving standard surveys from AOs would be temporarily put back under SA jurisdiction for the duration of the enforcement track. If a hospice provides evidence that they are back in compliance, avoiding termination, the hospice could then return to AO jurisdiction.

[45]As previously discussed, the 90-day termination track was the only enforcement action available to CMS prior to the CAA.

CMS officials told us the agency had implemented these new enforcement tools on three occasions. CMS officials told us that it anticipated finalizing guidance related to the use of these enforcement tools at the beginning of 2024.

About 10 Percent of Hospices Were Overdue for a Standard Survey at the End of May 2023; CMS Does Not Prioritize Among Overdue Surveys

According to data provided by CMS, about 10 percent of hospices that had been enrolled in Medicare for more than 3 years at the end of May 2023 were overdue for a standard survey. CMS has issued guidance that prioritizes overdue hospice surveys, but this guidance does not target hospices based on potential risk factors, such as length of time overdue or history of quality issues.

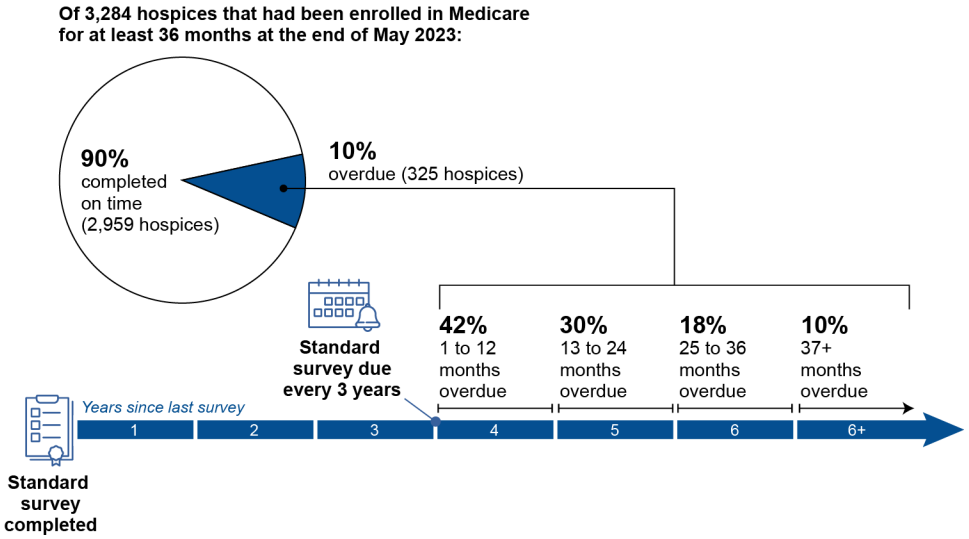
Some Hospices with Overdue Surveys Had Previous Quality Issues

Based on data provided by CMS, of the 3,284 hospices that had been enrolled in Medicare for more than 3 years at the end of May 2023, 325 hospices (10 percent) had not received a survey within the preceding 36 months.[46] (See fig. 2.) Of these 325 hospices,

- about 42 percent (135 hospices) had not been surveyed in 3 to 4 years,
- about 30 percent (98 hospices) had not been surveyed in 4 to 5 years,
- about 18 percent (59 hospices) had not been surveyed in 5 to 6 years, and
- about 10 percent (33 hospices) had not been surveyed in more than 6 years.

[46]This analysis of hospices with overdue surveys also excludes hospices that disenrolled from Medicare before the end of May 2023.

Figure 2: Hospices with Overdue Surveys, by the Length of Time Overdue, as of May 2023



Source: GAO analysis of Centers for Medicare & Medicaid Services data; keenan/stock.adobe.com (icons). | GAO-24-106442

Notes: This includes hospices that had been enrolled in Medicare for more than 3 years at the end of May 2023 (n = 3,284). Factors including the COVID-19 pandemic likely impacted the timeliness of standard surveys.

CMS data from the end of August 2023 indicate that 85 of the 325 hospices with overdue surveys received a standard survey between May 31, 2023, and August 25, 2023. About two-thirds of these (57) were among the hospices that were overdue for the least length of time—1 to 12 months, while one-third (28) were among the remaining hospices that were overdue by 13 to 37 months or more.

For about three-quarters of the 325 hospices overdue for a standard survey (240), SAs had performed their most recent standard surveys. AOs had performed the most recent standard surveys for the remaining one-quarter of these hospices (85).[47]

The majority of the 325 hospices with overdue standard surveys at the end of May 2023 were concentrated in a few states. Based on data provided by CMS, 205 hospices (more than 60 percent of hospices with overdue surveys) were located in five states. In four of these five states,

[47]The surveying entity that conducted each hospice's most recent standard survey may not be the entity that is responsible for conducting its overdue survey. As previously noted, hospices generally choose whether to be surveyed by their SA or an AO.

the majority of hospices with overdue surveys had not been surveyed in 4 years or more. In one state, more than 80 percent of hospices with overdue surveys had not had a standard survey in 4 years or more.

Some hospices with overdue surveys also had previous quality issues. Of the 325 hospices with overdue surveys we identified in the data provided by CMS,

- about 17 percent (55 hospices) had at least one previous serious quality deficiency, and
- about 11 percent (37 hospices) had at least one previous SSC.[48]

CMS Does Not Prioritize Among Overdue Hospice Surveys

CMS determines which hospices should be prioritized to receive standard surveys in each calendar year. For example, for fiscal year 2023, CMS instructed SAs to prioritize hospices with overdue standard surveys, generally, by including these hospices in its top priority tier for surveys to Medicare hospice providers.[49] However, CMS did not provide any direction to prioritize among hospices with overdue surveys; for example, to prioritize hospices that have a history of serious quality issues or hospices that are more than 12 months overdue for a survey. As previously noted, most of the overdue surveys that were subsequently completed between May and August 2023 were to the hospices that were overdue for the shortest length of time (between 1 and 12 months), rather than those that were overdue by 13 to 37 months or more.

CMS has attributed overdue surveys and constrained SA resources, in part, to challenges resulting from the COVID-19 public health emergency, including high numbers of retirements among surveyors and low numbers of applicants for open surveyor positions. Yet, overdue surveys were an issue for hospices in some states prior to the COVID-19 public health emergency. CMS does track the completion of standard surveys for both SAs and AOs throughout the year and requires SAs that are not

[48]Previous serious quality deficiencies and SSCs are only available as far back as 2017. The number of hospices with overdue surveys that also had previous SSCs may be understated, as we do not have complaints data for January through May 2023.

[49]Other types of hospice surveys that CMS included in the top priority tier (Tier 1) in fiscal year 2023 include representative sample validation surveys of deemed hospices and complaint investigations prioritized as Immediate Jeopardy. CMS included complaint investigations prioritized as Non-Immediate Jeopardy High in Tier 2 and initial surveys in Tier 4 (lowest priority). CMS did not assign any types of hospice surveys to Tier 3 in fiscal year 2023. See Centers for Medicare & Medicaid Services, *Fiscal Year (FY) 2023 Mission & Priorities Document (MPD) — Action,* 22-10-ALL (Baltimore, Md.: Sept. 28, 2022).

performing to a satisfactory level to prepare corrective action plans.[50] CMS officials told us that SA funding and staffing resources for surveys of all provider types are constrained and the agency has limited ability to address SA funding and staffing constraints.

CMS has a goal of ensuring the provision of high-quality hospice care to Medicare beneficiaries. Additionally, federal internal control standards state that agencies should identify, analyze, and respond to risks, and that control activities should be designed to achieve objectives and respond to risks.[51] Timely standard surveys are important for ensuring hospices meet Medicare quality standards and informing other CMS monitoring and enforcement activities, including identifying and responding to risks via the Special Focus Program.

As resources are finite, prioritizing overdue standard surveys for hospices with potential risk factors, such as length of time since the last standard survey or history of serious quality deficiencies, could help state survey agencies and accrediting organizations target those hospices that may be at risk for quality issues. Further, such a policy could be particularly useful for states with high numbers of hospices with overdue surveys where resource constraints may make it difficult to address overdue surveys while staying current with the regular survey workload.

[50]CMS tracks overdue standard survey rates for all Medicare provider types—including hospices—for each SA. Those that fail to meet pre-defined thresholds are required to develop and implement corrective action plans to address the identified problems. In fiscal year 2023, SAs were required to reduce the number of past-due standard surveys by 50 percent or more. See Centers for Medicare & Medicaid Services, *Fiscal Year (FY) 2023 State Performance Standards System (SPSS) Guidance,* 22-08-ALL (Baltimore, Md.: Sept. 20, 2022). CMS also collects information on overdue surveys for each AO as part of the AO survey requirements.

[51]See GAO-14-704G.

Stakeholders Identified Factors That May Hinder Enrollment or Access to Hospice Care, Particularly for Certain Beneficiaries; CMS has Taken Action to Improve Access

Stakeholders we interviewed described issues that Medicare beneficiaries may face in considering enrollment in the hospice benefit, as well as challenges they may face in accessing services once enrolled.[52] Further, stakeholders noted that some groups of beneficiaries faced unique challenges accessing care.

Specifically, stakeholders identified the following factors that may hinder hospice enrollment for some beneficiaries:

- **Forfeiture of curative care.** The need to forfeit curative care can impact some beneficiaries' willingness to enroll in the hospice benefit, according to several stakeholders. For example, according to three stakeholders, the hospice benefit may require that beneficiaries give up concurrent care that can be viewed as curative, but can also improve quality of life; this can cause patients to avoid hospice enrollment. One provider group shared that transfusions—which could be curative or palliative—can improve the way that beneficiaries feel at the end of their lives. However, according to this group, some hospices may be unable to offer the service. In its fiscal year 2024 hospice wage index and payment rate update proposed rule, CMS noted that blood transfusions, commonly thought of as curative, would be appropriate as a palliative treatment and could be covered under the hospice benefit when a beneficiary's care team determined it would be beneficial for symptom control.[53]
- **Trust in and understanding of the benefit.** Some stakeholders noted that there can be a general lack of trust in and understanding of the hospice benefit, which can affect enrollment. This can be related to the reluctance to forgo curative care. According to these stakeholders, this can also be related to a broader mistrust of the benefit. For example, one stakeholder said that some potential patients are concerned that care might be rationed. Also, a lack of a full understanding of the benefit can lead to beneficiaries deciding not to enroll or enrolling later than their eligibility for the benefit, according to these stakeholders. Three of the stakeholders we interviewed emphasized the importance of health care providers giving

[52]As previously noted, we spoke with six researchers, as well as representatives from 15 stakeholder groups, including those representing the hospice industry, surveyors, and consumers.

[53]Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements, 88 Fed. Reg. 20,022, 20,036 (Apr. 4, 2023).

beneficiaries a very clear and understandable explanation of the benefit.

- **Availability of caregiver support or other resources.** Some stakeholders we spoke with noted that beneficiaries without family or other caregiver support, or without the resources for supplemental caregiving, may not have the same opportunities for hospice enrollment as those with ample support. One stakeholder provided the example that hospices may be reluctant to enroll beneficiaries with housing instability and fewer family supports because of the work that would be required to provide hospice care to those beneficiaries.

Stakeholders also noted challenges accessing hospice services after enrollment.

- **Limited availability due to staffing shortages.** Several stakeholders noted that a lack of adequate hospice staff can affect access to hospice care. This shortage has included nurses and nurse aides, among others, according to four stakeholder groups. One of these stakeholder groups shared that the hospice market has been uniquely challenged by the staffing shortage in light of the unique patient population and concerns staff had entering patients' homes due to the COVID-19 pandemic. Two of these stakeholders noted that lower staffing numbers cause hospices to limit the number of beneficiaries they can take on.
- **Limited choice of providers.** Some stakeholders noted that, specific to beneficiaries in nursing homes, business relationships can limit beneficiaries access and choice of providers. For example, one stakeholder group noted that in order to provide hospice services in a nursing home the nursing home generally contracts with hospice providers. However, nursing homes may limit the number of hospice providers they allow.

In addition to the above, stakeholders noted that there are factors and challenges for hospice enrollment and access that are unique to certain groups of beneficiaries, which is consistent with research in the field. (See fig. 3.)

Figure 3: Examples of Unique Hospice Access Challenges Certain Groups of Medicare Beneficiaries May Face

Group of beneficiaries	Examples of access challenges
Rural beneficiaries 	• Seven stakeholders noted that beneficiaries living in rural areas are less likely to access hospice care or have fewer options for such care. • This is consistent with research from the Medicare Payment Advisory Commission that indicated that, while rural utilization of hospice care had been growing pre-pandemic, rural utilization was lower than urban utilization in 2021.[a]
Beneficiaries with high-cost and complex care 	• Four stakeholders noted that hospices do not have incentives to provide or maintain comprehensive care to beneficiaries that require higher-cost treatment, such as dialysis. In addition, patients with uncertain trajectories (e.g., those with dementia) may experience disrupted care because of early discharge, according to one stakeholder. • This is consistent with research from a 2021 study that found that patients receiving expensive and complex treatments for heart failure and cystic fibrosis may have difficulty accessing hospice care, based on a survey of hospices' likelihood in accepting different patient profiles.[b]
Non-White beneficiaries 	• Four stakeholders noted that non-White beneficiaries may face unique access concerns, and one stakeholder noted that trust can be a factor in non-White beneficiary interest in accessing hospice care. • This is consistent with research from the Medicare Payment Advisory Commission that found that while hospice use rates increased or were stable among Black, Hispanic, Asian American, and North American Native Medicare beneficiaries in 2021, those use rates remained lower than for White beneficiaries.[a]

Source: GAO analysis of stakeholder interviews and selected research; elenabsl/stock.adobe.com (illustrations). | GAO-24-106442

Notes: We interviewed a set of six researchers and 15 stakeholder groups, including five consumer advocacy groups, five provider groups, and five surveyor entities. The views of those researchers and stakeholder groups we selected are not generalizable to all such groups.

[a]See Medicare Payment Advisory Commission, *March 2023 Report to the Congress: Medicare Payment Policy* (Washington, D.C.: Mar. 15, 2023).

[b]See E. Trandel, M. Bannon, and D. Kavalieratos, "Disparities in Hospice Access for Patients with Costly or Complex Illnesses," *Journal of Pain and Symptom Management*, vol. 61, no. 3 (March 2021).

CMS has taken steps that may help improve access to hospice care. For example:

- In 2022, CMS updated its Framework for Health Equity and Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Areas. These frameworks outline efforts to advance health equity; increase access to health care benefits, supports, services, and coverage; and improve outcomes for patients

seeking care from all provider types, including hospice.[54] For example, included among the priorities in the health equity framework are building capacity of the health care workforce to reduce health care disparities, and increasing all forms of accessibility to health care services and coverage. The geographic framework recognizes the unique needs of rural, tribal, and other geographically isolated communities and identifies CMS resources for hospice providers serving tribal communities.[55]

- CMS increased payment rates for certain levels of hospice care in its fiscal year 2020 hospice wage index and payment rate update final rule.[56] CMS stated that aligning payment with the cost of providing care should have a positive effect on access to needed levels of care.
- CMS noted interest in focusing on improved access to hospice care in its fiscal year 2024 hospice wage index and payment rate update final rule.[57] CMS reviewed information received from industry stakeholders and others about the challenges related to providing certain levels of care. Included in the responses were observations about the importance of clear information for families on what is and is not covered under hospice, as well as commentary regarding the increasing costs of palliative treatments and the associated financial risks for hospices. CMS noted that it planned to consider the information provided for action in future rulemaking.
- CMS also tested a model, administered from 2016 through 2021, that allowed patients to receive supportive services alongside curative care. An evaluation of the Medicare Care Choices Model found that participants were 18 percentage points more likely to use the hospice benefit before death than were comparison beneficiaries, and that

[54]See Centers for Medicare & Medicaid Services, *The CMS Framework for Health Equity (2022-2032)* (Baltimore, Md.: 2022); and Centers for Medicare & Medicaid Services, *The CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Areas* (Baltimore, Md.: 2022).

[55]See Centers for Medicare & Medicaid Services, *Long Term Services and Supports Technical Assistance Center, Hospice and Palliative Care*, accessed January 26, 2024, https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/focus-areas/hospice-palliative-care.

[56]Medicare Program; FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements, 84 Fed. Reg. 38,484, 38,491 (Aug. 6, 2019).

[57]Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements, 88 Fed. Reg. 51,164, 51,167 (Aug. 2, 2023).

outcomes were improved for all beneficiary groups participating in the model, including rural and non-White beneficiaries.[58]

Conclusions

The CAA provided CMS with additional authorities and responsibilities for overseeing hospices participating in the Medicare program. CMS has taken steps to implement some of the CAA provisions, such as establishing a Special Focus Program for some poorly performing hospices. However, CMS has not fully implemented other provisions, including those related to enforcement tools such as civil monetary penalties. The full implementation of these CAA provisions is important so that CMS has the ability to hold hospices accountable for correcting serious quality deficiencies and returning to compliance with quality standards, as well as to advance transparent and consistent measurement of hospice quality compliance.

Standard surveys are important for monitoring hospice compliance with quality standards. They also provide CMS the necessary information to apply, as warranted, new enforcement tools, such as civil monetary penalties on noncompliant hospices and the Special Focus Program. While CMS generally prioritizes hospice providers that are overdue to receive a survey, funding and staffing issues faced by SAs constrain the completion of all overdue surveys. For the 10 percent of hospices that had an overdue survey as of the end of May 2023, including those that were multiple years overdue or had a history of serious quality deficiencies, CMS does not have the current survey information needed to oversee compliance and implement these new enforcement tools. Prioritizing overdue standard surveys for hospices based on potential risk factors—such as the length of time since the most recent standard survey or history of quality issues—can target hospices that may be most at risk for quality issues. In addition, it would help mitigate state survey agencies' funding and staffing resource constraints.

Recommendations for Executive Action

We are making the following four recommendations to CMS:

The CMS Administrator should fully implement the new enforcement tools, including issuing planned internal guidance, to enable the agency to use these tools to address hospices out of compliance with Medicare quality standards. (Recommendation 1)

[58]See K. Kranker et al., "Evaluation of the Medicare Care Choices Model," (Princeton, N.J.: Mathematica, November 2023).

The CMS Administrator should make hospice survey results publicly available on Care Compare such that the information is prominent, easily accessible, and readily understandable. (Recommendation 2)

The CMS Administrator should fully implement efforts to measure and reduce inconsistency in survey results among all surveyors, including SAs and AOs. (Recommendation 3)

The CMS Administrator should instruct SAs and AOs to prioritize the completion of standard surveys for hospices that are overdue for a survey based on potential risk factors, which could include the amount of time overdue or evidence of past quality issues. (Recommendation 4)

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment, and the agency's comments are reprinted in appendix II. HHS concurred with three of four recommendations and did not concur with the fourth. HHS also provided us with technical comments, which we incorporated into the report as appropriate.

With regard to our first recommendation—that CMS fully implement the new enforcement tools—HHS concurred, noting that the agency has developed an online training course that became available in October 2022. HHS also noted that the agency is in the process of issuing guidance for surveyors to assist and promote consistency in applying the new enforcement tools. We believe that these actions, if implemented effectively, should address the recommendation.

With regard to our second recommendation—that CMS make hospice survey results publicly available on Care Compare—HHS concurred, and reiterated its plans to publicly post survey information on Care Compare to offer patients and their families more information and transparency on hospice quality. HHS noted that the agency is working on a process to enter survey results into an existing database and export those results into Care Compare to display in a manner that is prominent, easily accessible, readily understandable, and searchable. We believe that these actions, if implemented effectively, should address the recommendation.

With regard to our third recommendation—that CMS fully implement efforts to measure and reduce inconsistency in survey results among all surveyors—HHS concurred and noted steps that the department has taken to reduce inconsistency, including providing a common training across surveyors. The department also noted proposed rulemaking that

would expand CMS validation programs for AO surveys to include direct-observation surveys, among other things. Additionally, HHS noted it plans to continuously look for opportunities to improve consistency among all surveyors. Until CMS takes steps to address our recommendation, such as uniformly measuring inconsistency and requiring corrective steps for survey entities that are found to be inconsistent, hospice compliance with quality standards may not be consistently assessed.

With regard to our fourth recommendation—that CMS instruct SAs and AOs to prioritize the completion of standard surveys for hospices that are overdue for a survey based on potential risk factors—HHS did not concur. According to HHS, AOs have completed all overdue standard surveys resulting from the COVID-19 public health emergency. In addition, according to HHS, SAs have been directed to first prioritize the investigation of patient complaints, and as a secondary priority, statutorily required survey and recertification of providers, including hospices. HHS further noted that it monitors timely completion of SA surveys, and that it will work with the limited number of states with backlogs to individually address performance concerns.

While CMS has identified categories that SAs are to prioritize, we maintain that, when states or other survey entities have backlogs, taking a risk-based approach to prioritization is advisable within such categories. For example, we identified that 17 percent of hospices that were overdue for a survey at the time of our analysis had evidence of previous quality concerns. In addition, we found that more than half of the hospices that we found to have overdue surveys were located in five states. Given that SA resources are finite, instructing states with multiple hospices that are overdue for a standard survey to prioritize among those hospices based on potential risk factors—such as evidence of previous quality concerns—upon reaching the recertification priority category could be one way to help state survey agencies target those hospices that may be at risk for quality issues. Moreover, in its comments, HHS stated that its Fiscal Year 2024 Mission & Priorities Document focuses on oversight activities that are most likely to impact patient health and safety. Prioritizing overdue surveys of hospices that are most at risk for not complying with health and safety standards as we recommended, would align with HHS's stated oversight focus. Furthermore, while HHS asserts that survey backlogs are specific to SAs at the present time, this recommendation also would apply to AOs, as this could change in the future.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, the

Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report is available at no charge on the GAO website at https://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or GordonLV@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

Leslie V. Gordon
Director, Health Care

List of Committees

The Honorable Ron Wyden
Chairman
The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate

The Honorable Cathy McMorris Rodgers
Chair
The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Jason Smith
Chairman
The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
House of Representatives

Appendix I: Scope and Methodology of Data Analysis

This appendix provides details on our scope and methodology in addressing our second and third reporting objectives, which

- describe the extent to which hospices were cited for serious quality deficiencies from 2017 through 2022, and Centers for Medicare & Medicaid Services (CMS) efforts to monitor hospices with serious quality deficiencies; and
- describe the number of hospices with overdue surveys as of the end of May 2023, and examine CMS's efforts to prioritize survey administration.

To address these two objectives, we used Medicare enrollment, survey, and complaint data, as well as a custom data file provided by CMS for hospices that had been enrolled in Medicare for at least 36 months as of May 2023. To assess the reliability of these data, we examined relevant documentation, interviewed knowledgeable agency officials, conducted simple data checks, and took steps to clean the data, as appropriate. We determined that these data were sufficiently reliable for the purpose of our objectives.

To describe the extent to which hospices were cited for serious quality deficiencies in surveys from 2017 through 2022, we analyzed standard survey data from CMS's Certification and Survey Provider Enhanced Reports dataset; the Accrediting Organization System for Storing User Related Experiences dataset, and the Internet Quality Improvement & Evaluation System dataset. In addition, we analyzed complaints data from the Automated Survey Process Environment Complaints/Incidents Tracking System dataset. We included in our analyses all Medicare hospice providers that received payment for services provided to Medicare beneficiaries, defined by having at least one paid claim in CMS's 2017 through 2022 Hospice Standard Analytic Files. Through these parameters, we started with 6,622 hospices that billed Medicare between 2017 and 2022. We then counted the number and share of hospices that had the following:

Serious quality deficiencies. To count serious quality deficiencies, defined as condition-level deficiencies, we identified hospices that underwent at least one standard survey in each of the 3-year reporting cycles in our study time frame (2017 through 2019 and 2020 through

2022).[1] This allowed us to detect the extent to which hospices had serious quality deficiencies in either or both reporting cycles. For the 614 hospices (15 percent) with more than one standard survey in either of our two 3-year cycles, we randomly selected one standard survey in each of the 3-year reporting cycles within our study time frame.[2] Then we only counted serious quality deficiencies from the one randomly selected standard survey within each of those reporting cycles.[3] Of the over 6,600 hospices billing Medicare between 2017 and 2022, 4,203 (63 percent)

[1]While we selected this time frame because it aligns with the requirement that hospices receive a standard survey no less frequently than once every 3 years, CMS calculates survey timeliness on a rolling basis. That is, hospices observe varying 3-year reporting cycles between their standard surveys, and timeliness is calculated from the date of a given hospice's last standard survey. The actual amount of time between standard surveys may be more or less than 36 months.

Standard surveys can include up to two parts: a Health survey and a Life Safety Code survey. All hospices receive a Health survey; only hospices with their own inpatient facilities receive a Life Safety Code survey. These survey types are sometimes recorded separately in CMS's survey data. To ensure that some hospices did not have more serious quality deficiencies because they were subject to an additional survey component, we excluded from our analysis all separately recorded Life Safety Code surveys.

[2]Because having more than one standard survey in a given reporting cycle would have provided a greater opportunity for a hospice to receive a serious quality deficiency, we only included deficiencies from the randomly selected surveys in those cases. As a result, our counts are conservative in those cases.

Hospices may have had multiple standard surveys in one 3-year reporting cycle for multiple reasons. For example, CMS may have put the hospices on an enforcement track after a substantiated complaint and conducted a full standard survey sooner than otherwise required. Alternatively, CMS officials noted that SAs may have performed a full standard survey sooner than required for hospices that chose to move from deemed status (surveyed by one of the AOs) to non-deemed status (surveyed by the appropriate SA).

Of the 614 hospices with more than one standard survey in either of our two 3-year cycles, 378 (62 percent) had more than one standard survey between 2017 and 2019 and one between 2020 and 2022; 219 (36 percent) had one standard survey between 2017 and 2019 and more than one between 2020 and 2022; and 17 (3 percent) had more than one standard survey in each 3-year cycle.

[3]Because some hospices had more standard surveys during the study period than others, some had greater opportunity for the identification of serious quality deficiencies. For this reason, we randomly selected one standard survey within each of the two reporting cycles to standardize across hospices with multiple standard surveys in one or both cycles and included only serious quality deficiencies from that survey. The survey selection method ultimately had minimal impact on the number of hospices with serious quality deficiencies between 2017 and 2022: when analyzing all standard surveys, 26 percent of hospices had such deficiencies; when analyzing randomly selected standard surveys, 23 percent had such deficiencies; and when analyzing the most recent standard surveys in each 3-year cycle (a survey methodology selection we also considered), 22 percent had such deficiencies.

had one or more standard surveys in each reporting cycle, and 2,106 (32 percent) had one or more standard surveys in just one of the two survey reporting cycles within our study time frame.[4]

To ensure that some hospices did not have more serious quality deficiencies because they were subject to more quality requirements, we limited this analysis to deficiencies associated with Medicare Conditions of Participation that were applicable to all—or nearly all—hospices. To do this, we excluded deficiencies associated with two Conditions of Participation: one that was only applicable to a small number of rural hospices, and one that was applicable to hospices that provide inpatient care in their own facilities.

Substantiated severe complaints (SSC). In addition, we counted SSCs, defined as the two most concerning levels of complaints that can be filed against a hospice provider. We analyzed hospice complaint data over the entire 6-year period for all 6,622 hospices because complaints can be filed against a hospice at any point outside of the standard survey process. We excluded from this analysis complaints that appeared to be duplicated in the database. For example, we excluded all but one complaint when a hospice had multiple complaints of the same severity level made on the same day.

To describe the number of hospices with overdue surveys at the end of May 2023, we reviewed a custom data file CMS pulled from the Accrediting Organization System for Storing User Related Experiences dataset and the Internet Quality Improvement & Evaluation System dataset that included the number of months since the most recent standard survey for all hospices that had been enrolled in Medicare for at least 36 months as of the end of May 2023. CMS identified 3,284 such hospices. We analyzed these data to determine the number of hospices with overdue standard surveys (i.e., hospices that had not had a standard survey during the 37 months prior to the end of May 2023). We also analyzed these data to determine the number of hospices that had not had a standard survey in more than 36, 48, 60, or 72 months, and to identify states that had the highest shares of hospices with overdue standard surveys.

[4]The remaining 5 percent of hospices had no evidence of standard surveys conducted between 2017 and 2022.

There are two limitations to our analysis of hospices' serious quality deficiencies and overdue standard surveys.

Our analysis may understate the true extent of serious quality deficiencies. We excluded certain types of surveys from our serious quality deficiency analysis, including validation surveys, Life Safety Code surveys, and complaint investigations, because not all hospices are subject to these types of surveys. Furthermore, as previously noted, for those hospices with multiple standard surveys in a given 3-year reporting cycle within our study time frame, we limited our count of serious quality deficiencies to those from randomly selected standard surveys. We did this because having more than one standard survey in a given 3-year reporting cycle would provide a greater opportunity for a hospice to receive a serious quality deficiency, making comparisons within a reporting cycle challenging. Some hospices may have had serious quality deficiencies on standard surveys that were not randomly selected for inclusion in the analysis. However, only 15 percent of hospices were subject to this randomized selection. Additionally, because the population of hospices included in this analysis is limited to those hospices with at least one standard survey in each 3-year reporting cycle, inferences cannot be drawn about all hospices enrolled in Medicare between 2017 and 2022.[5]

Temporary COVID-19-related restrictions on the administration of standard surveys likely influenced our results. The number of hospices with serious quality deficiencies and overdue surveys may have been impacted by the pandemic-related pause in standard surveys CMS instituted between March and August 2020. This pause delayed surveys for some hospices in 2020, and surveyors may not have been able to both make up these delayed surveys and conduct newly due surveys in the time following the pause. If fewer standard surveys were performed during 2020, fewer hospices may have been cited with serious quality deficiencies in the most recent survey reporting cycle (2020 through 2022). This potential temporary reduction in the administration of standard surveys suggests that our results may not be comparable across reporting cycles. Additionally, if surveyors were unable to fully address the impacts of the survey pause by the end of May 2023, more hospices may be overdue for a standard survey.

[5]Specifically, hospices that first enrolled in Medicare in 2020 or later and hospices that did not receive a standard survey in either of the two 3-year reporting cycles were excluded from this analysis.

Appendix II: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

April 15, 2024

Leslie V. Gordon
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Gordon:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, **"MEDICARE HOSPICE: CMS Needs to Fully Implement Statutory Provisions and Prioritize Certain Overdue Surveys" (GAO-24-106442).**

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Melanie Anne Egorin

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT TITLED: MEDICARE HOSPICE: CMS NEEDS TO FULLY IMPLEMENT STATUTORY PROVISIONS AND PRIORITZE CERTAIN OVERDUE SURVEYS (GAO-24-106442)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office (GAO) draft report. HHS is committed to fully implementing the Consolidated Appropriations Act, 2021 (CAA) and providing Medicare beneficiaries access to high-quality hospice care.

Hospice, at its core, provides palliative care and support for people who are terminally ill and for their families. People who elect to receive hospice care generally receive their care at home by a specially trained team of professionals and caregivers. Hospices provide care for the "whole person," which means not only providing care directed at meeting the patient's physical needs, but care that meets their emotional, social, and spiritual needs as well.

HHS has been hard at work implementing new survey and enforcement requirements in the CAA related to hospice oversight, with a goal of making sure that hospices enrolled in Medicare are fully able to provide high quality care. As GAO noted in their report, HHS has fully implemented five and partially implemented three of the eight provisions related to hospice oversight required through the CAA. Last year, HHS finalized policies, enacted in the CAA, requiring surveyors to use multidisciplinary survey teams, prohibiting surveyor conflicts of interest (such as prohibiting surveyors from performing a survey of a provider where they have an ownership interest or are employed), and requiring surveyors from accrediting organizations (AOs) to complete comprehensive training and testing. Additionally, AOs are now required to collect standardized survey deficiency information in the same manner and format used by State Survey Agencies (SAs), and this information is disclosed on the Quality, Certification, and Oversight Reports (QCOR) public facing website. HHS also will publicly post SAs' and AOs' survey information on Care Compare to offer patients and their families even more information and transparency into the quality of care provided by hospices in their area.

HHS oversees the quality of care provided by hospices through the survey and certification process. SAs and AOs are required to conduct health and safety surveys of hospices to ensure they provide all required services and meet all hospice conditions of participation. These surveys must occur before hospices are initially certified for participation in Medicare and at least every three years thereafter. In addition, beneficiaries, caregivers, and others may file complaints against hospice providers at any time. An infographic on how to file a complaint about hospice care can be found on the Centers for Medicare & Medicaid Services' (CMS) website.[1] SAs and AOs 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 conditions of participation in the Medicare program has placed the health and safety of residents and patients at risk of serious injury, harm, impairment, or death, surveyors must identify the noncompliance as an immediate jeopardy situation. To improve oversight efforts, HHS has provided guidance to surveyors for quickly

[1] CMS, How to File a Complaint About Hospice Care, Accessed at: https://www.cms.gov/files/document/hospicecomplaintinfographic04082022.pdf

identifying and handling immediate jeopardy situations regardless of provider type in Appendix Q of the State Operations Manual (SOM). In March 2019, HHS made revisions to Appendix Q to clarify what information is needed to identify immediate jeopardy cases across all healthcare provider types.[2] As part of this guidance, HHS has required a standardized notification process for surveyors to follow when immediate jeopardy is identified to ensure that providers are notified as soon as possible of an immediate jeopardy finding. This process has increased transparency, and improved timeliness and clarity of communication to providers.

Another way HHS is working to improve hospice quality of care is through the hospice special focus program (SFP). As required by the CAA, HHS implemented an SFP to address poor-performing hospices through increased regulatory oversight. Hospices selected for the program will be surveyed more frequently and subject to progressive enforcement remedies as appropriate. Hospices that do not improve are considered for termination from Medicare participation.

In addition to survey and certification improvements, HHS recently revisited and revitalized our hospice program integrity strategy, focusing on identifying bad actors and addressing fraudulent activity to minimize impacts to beneficiaries in the Medicare program. As part of this strategy, HHS embarked on a nationwide hospice site visit project, making unannounced site visits to every Medicare-enrolled hospice.[3] Our goal was to protect patients and their families from engaging with fraudulent actors by making sure that each hospice is operational at the address listed on their enrollment form.

HHS remains diligent in our duties to oversee the quality of care in hospices across the country, and we appreciate the work of the GAO in this area and will continue to work with them as we further strengthen hospice oversight.

GAO's recommendations and HHS's responses are below.

GAO Recommendation 1
The CMS Administrator should fully implement the new enforcement tools, including issuing planned internal guidance, to enable the agency to use these tools to address hospices out of compliance with Medicare quality standards.

HHS Response
HHS concurs with the GAO's recommendation. The CAA directed the Secretary to establish and implement new enforcement remedies for noncompliant hospice programs. Effective January 1, 2022, HHS may impose one or more enforcement remedies instead of, or in addition to, termination of the hospice program's participation in the Medicare program.[4] The new remedies

[2] CMS, Revisions to Appendix Q, Guidance on Immediate Jeopardy. QSO-19-09-ALL. March 5, 2019. Accessed at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-09-ALL.pdf.
[3] CMS Blog, CMS is Taking Action to Address Benefit Integrity Issues Related to Hospice Care; Accessed at: https://www.cms.gov/blog/cms-taking-action-address-benefit-integrity-issues-related-hospice-care
[4] *Federal Register:* "Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Model Expansion; Home Health and Other

that may be imposed include civil money penalties, suspension of payment for all new patient admissions, appointment of temporary management, directed plan of correction, and directed in-service training. HHS developed an "Enforcement Process for Home Health Agency and Hospice Programs" online training course that went live in October 2022 via the HHS Quality, Safety and Education Portal (QSEP) site.[5] Additionally, HHS is in the process of issuing guidance for surveyors to assist and promote consistency in applying remedies for hospices that are determined to be out of compliance with Medicare requirements. The guidance, once published, will be available in the SOM, Chapter 10.

GAO Recommendation 2
The CMS Administrator should make hospice survey results publicly available on Care Compare such that the information is prominent, easily accessible, and readily understandable.

HHS Response
HHS concurs with the GAO's recommendation. In addition to SA surveys, AOs are now required to collect standardized survey deficiency information in the same manner and format used by SAs (using the CMS-2567 form), and this information is disclosed on the QCOR public facing website. HHS also will publicly post SAs' and AOs' survey information on Care Compare to offer patients and their families even more information and transparency into the quality of care provided by hospices in their area. To achieve these goals, HHS is working to create a process to first enter the AO survey information into the internet Quality Improvement and Evaluation System (iQIES), which currently stores state survey data, and subsequently extract and import the data from SA and AO surveys into Care Compare and display it in a manner that is prominent, easily accessible, readily understandable, and searchable.

GAO Recommendation 3
The CMS Administrator should fully implement efforts to measure and reduce inconsistency in survey results among all surveyors, including SAs and AOs.

HHS Response
HHS concurs with the GAO's recommendation. As required by the CAA, HHS has taken steps to measure and reduce inconsistency in the application of survey results among surveyors. For example, HHS has provided a common platform for basic training to ensure a consistent survey approach by all surveying entities. HHS is also developing annually identified "focus areas" to develop Surveyor Skills Review (SSR) trainings. SSR training addresses areas identified as needing enhanced training or correction to improve accuracy and consistency in the survey process.

In addition, the CAA requires that AOs now submit their survey findings on the CMS-2567 form (statement of deficiencies). This is the same form that the SAs use for their survey findings. In 2021, HHS issued a final rule implementing this requirement, as well as the requirement that SA

Quality Reporting Program Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; and COVID-19 Reporting Requirements for Long-Term Care Facilities; Final rule" (86 FR 62240)(11/9/2021).

[5] QSEP Driving Healthcare Quality, Training Menu, Enforcement Process for Home Health Agency and Hospice Program. Accessed at: https://qsep.cms.gov/pubs/CourseMenu.aspx?cid=0CMSENFPRCS_HHAHOSPC

and AO surveyors receive comprehensive training and testing.[6] HHS is working to create a process to first enter the AO survey information into iQIES, which stores state survey data, and subsequently extract and import the data from SA and AO surveys into Care Compare and display it in a manner that is prominent, easily accessible, readily understandable, and searchable.

Lastly, HHS issued a proposed rule aiming to address inconsistency in survey results.[7] Proposed changes include standardizing the AO application process to require AO standards to match the Medicare Conditions of Participation and expanding CMS validation programs of AO surveys to include direct-observation surveys. HHS plans to continuously look for opportunities to improve consistency among all surveying entities through training, guidance, monitoring, and direct observation validation surveys.

GAO Recommendation 4

The CMS Administrator should instruct SAs and AOs to prioritize the completion of standard surveys for hospices that are overdue for a survey based on potential risk factors, which could include the amount of time overdue or evidence of past quality issues.

HHS Response

HHS non-concurs with the GAO's recommendation. The AOs have completed all overdue standard surveys resulting from the COVID-19 public health emergency. SAs have been instructed to follow survey work prioritization according to the CMS Mission & Priorities document (MPD). The MPD is an annual document that directs the work of SAs based on regulatory changes, adjustments in budget allocations, new initiatives, and new requirements based on statute. These priorities aim to balance the specificity needed to meaningfully address the most pressing surveys with the administrative burdens of prescriptive prioritization of different categories of surveys. The fiscal year 2024 MPD was communicated via an Admin Info memo on December 12, 2023.[8] As part of this memo, HHS outlined that in light of the complaint backlog that states continue to face from the COVID-19 public health emergency and the limited resources due to flatlined budgets, CMS has established the following priorities, which focus on oversight that is most likely to impact patient health and safety:

1. Investigation of patient complaints, as these are active quality concerns that must be reviewed to protect the health and safety of the public;
2. Statutorily required survey and recertification of facilities such as nursing homes, home health agencies, and hospices as required by current law; and
3. Survey and recertification of all other facilities, as required by CMS policy with consideration of available funding once priorities one and two have been accomplished.

[6] *Federal Register:* "Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Model Expansion; Home Health and Other Quality Reporting Program Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; and COVID-19 Reporting Requirements for Long-Term Care Facilities; Final rule" (86 FR 62240)(11/9/2021).

[7] *Federal Register:* "Medicare Program; Strengthening Oversight of Accrediting Organizations (AOs) and Preventing AO Conflict of Interest, and Related Provisions; Proposed Rule"(89 FR 11996)(2/15/2024)

[8] CMS, Center for Clinical Standards and Quality. Fiscal Year (FY) 2024 Mission & Priorities document (MPD) – Action, December 13, 2023. Accessed at: https://www.cms.gov/files/document/admin-info-24-07-all.pdf.

HHS monitors timely completion of state agency surveys via the State Performance Standards System. Given the issue of survey backlogs is specific to SAs, and not AOs, and that there are a limited number of states still addressing survey backlogs, HHS will work with these states individually to address performance concerns related to timeliness of surveys.

Appendix III: GAO Contact and Staff Acknowledgments

GAO contact

Leslie V. Gordon, (202) 512-7114 or GordonLV@gao.gov

Staff acknowledgments

In addition to the contact named above, Iola D'Souza (Assistant Director), Kate Nast Jones (Analyst-in-Charge), Todd Anderson, David Jones, Drew Long, Lisa Minich, Ravi Sharma, and Jennifer Whitworth made key contributions to this report.

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