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October 2019

MEDICARE HOSPICE CARE

Opportunities Exist to Strengthen CMS Oversight of Hospice Providers

Accessible Version

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GAO Highlights

Highlights of GAO-20-10, a report to the Ranking Member, Committee on Finance, U.S. Senate

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Opportunities Exist to Strengthen CMS Oversight of Hospice Providers

Why GAO Did This Study

Since 2000, there has been substantial growth in Medicare payments for hospice services and the number of Medicare beneficiaries using hospice. This growth has been accompanied by an increase in the number of providers (primarily an increase in for-profit providers), reaching approximately 4,500 providers by 2017.

GAO was asked to review aspects of Medicare's hospice program. This report, among other things, (1) compares quality scores and other potential indicators of quality for for-profit and non-profit hospices; and (2) examines opportunities for strengthening CMS's oversight of hospice providers.

GAO analyzed CMS data on hospice care for 2014 through 2017—the latest years for which full-year data were available at the time of GAO's analysis—and reviewed research on hospice care. GAO interviewed CMS officials, researchers, provider associations, a survey agency association, and a non-generalizable sample of hospice providers selected in part through referrals from other stakeholders. GAO also reviewed relevant statutes, regulations, documents, and enforcement data.

What GAO Recommends

CMS should incorporate the use of additional information that could be used to identify quality of care issues into its survey process for hospice oversight. Congress should consider giving CMS authority to establish additional enforcement remedies for hospices that do not meet federal health and safety requirements. The Department of Health and Human Services concurred with GAO's recommendation.

What GAO Found

Medicare's hospice benefit provides palliative care to beneficiaries with terminal illnesses and a life expectancy of 6 months or less. GAO's review of 2017 data from the Centers for Medicare & Medicaid Services (CMS) found that for-profit and non-profit hospices had, on average, similar scores on CMS's current quality measures that indicate hospice performance in areas such as pain assessment and discussion of beneficiary treatment preferences. However, for-profits were more often among the subset of providers with the lowest scores on certain quality measures GAO reviewed. In addition to analyzing providers' scores on CMS quality measures, GAO analyzed provider performance on other indicators, identified by researchers, that could signal quality issues and found performance varied among for-profit and non-profit hospices. One of the other quality indicators GAO analyzed was the rate of beneficiaries discharged from hospice prior to death, which in some cases could indicate dissatisfaction with care leading to the beneficiary's decision to leave the hospice provider. In addition, GAO examined the number of provider visits to give medical and emotional support within the last few days of a beneficiary's life. With regard to these indicators, for 2017, GAO found the following, among other things:

- 472 hospice providers (462 for-profits and 10 non-profits) had a high rate of discharging beneficiaries prior to death (50 percent or more were discharged). According to research, a high discharge rate could, in some cases, be an indicator of poor quality of care or of provider misuse of the benefit, in that the hospice may be enrolling beneficiares who are not eligible for hospice care.
- 83 providers (80 for-profits and 3 non-profits) did not have hospice staff (such as nurses, physicians, or nurse practitioners) visit beneficiaries within the last 3 days of their life—a critical time in providing quality care, according to researchers GAO interviewed.

CMS's oversight of the quality of care provided by hospice providers consists primarily of inspections—called surveys—of hospice providers. GAO found that, while CMS instructs surveyors to review previous survey findings and complaints, CMS does not instruct surveyors to use information on providers' performance on quality measures or other potential indicators of quality as part of the survey process. For example, CMS does not instruct surveyors to consider whether a hospice provided staff visits during beneficiaries' last week of life. According to research, this information could be used to enhance the survey process. GAO also found that CMS is limited to one enforcement option—termination of the Medicare provider agreement—which CMS uses rarely and generally only when providers fail to correct within the required time frame the most serious violations of federal health and safety requirements. According to two researchers, additional remedies, such as civil monetary penalties, could enhance CMS's oversight by addressing performance problems that do not merit termination and incentivize agencies to improve quality of care. CMS uses a range of remedies for other provider types, such as home health agencies and nursing homes, but lacks authority to impose such additional sanctions on hospices.

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Abbreviations

CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare & Medicaid Services
HHS OIG	Department of Health and Human Services' Office of the Inspector General
MedPAC	Medicare Payment Advisory Commission

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

October 18, 2019

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

Dear Senator Wyden,

Medicare began offering the hospice benefit in 1983 as a means of providing palliative care, or pain and symptom management, to beneficiaries with a life expectancy of 6 months or less. According to the Centers for Medicare & Medicaid Services (CMS), the goal of hospice care is to help terminally ill Medicare beneficiaries live as normal lives as possible while remaining primarily in their home environment. Enrolling in the hospice benefit is a beneficiary's choice and, when doing so, the beneficiary is choosing to forego curative treatment of their terminal illness and related conditions. Medicare will, however, continue to pay for curative treatment of conditions that are not related to the terminal illness.

Since 2000, there has been a substantial increase in both Medicare spending for hospice services and the number of Medicare beneficiaries using these services. According to CMS, Medicare payments to hospices increased from $2.8 billion in fiscal year 2000 to approximately $17.7 billion in fiscal year 2017, while the number of Medicare hospice beneficiaries nearly tripled, from 513,000 to nearly 1.5 million.[1] CMS projects total Medicare hospice payments will continue to increase at a rate of 8.5 percent annually.[2] This is greater than the projected 7.4 percent annual increase for Medicare spending overall based on CMS's projections.[3] According to CMS, these increases reflect an increase in the number of Medicare beneficiaries overall, greater beneficiary awareness

[1]According to the Medicare Payment Advisory Commission (MedPAC), Medicare covered more than 90 percent of hospice patient days in 2017, and half of Medicare decedents used hospice in that year. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: Mar. 15, 2019).

[2]Medicare Program; FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements, 84 Fed. Reg. 17,570, 17,573 (proposed Apr. 25, 2019).

[3]In February 2019, CMS's Office of the Actuary released 2018-2027 projections of national health expenditures.

of the Medicare hospice benefit, and beneficiaries' growing preference for receiving end-of-life care in their home or community-based settings.

The increases in Medicare hospice expenditures and beneficiaries have been accompanied by an increase in the number of hospice providers. According to the Medicare Payment Advisory Commission (MedPAC), the number of hospices doubled from about 2,300 to nearly 4,500 from 2000 through 2017, and for-profit hospices accounted for the entirety of the net increase during that time period. As a result, for-profit hospices in 2017 made up about two-thirds of all hospices compared to less than a third in 2000.[4]

Given this change in the makeup of the universe of hospice providers, you asked us to examine key characteristics of hospice beneficiaries and providers, including any differences by hospice ownership type (e.g., for-profit and non-profit providers).

This report

1. compares the number of Medicare hospice beneficiaries, beneficiary characteristics, and Medicare payments of for-profit and non-profit hospices;
2. compares hospice providers' scores on CMS's quality measures and other potential indicators of quality for for-profit and non-profit hospices; and
3. examines opportunities for strengthening CMS's oversight of hospice providers.

To compare the number of Medicare hospice beneficiaries, beneficiary characteristics, and Medicare payments of for-profit and non-profit hospices, we analyzed CMS data on hospice providers, beneficiaries, and services for 2014 through 2017, the latest years for which full-year data were available during the period we conducted our analysis.[5] We used

[4]Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, 317-318.

[5]Specifically, we used CMS's Provider of Services file (which contains information about hospice providers), Medicare Denominator file (which contains information about Medicare beneficiaries), and Hospice Standard Analytic File (which contains claims submitted by providers for hospice services provided to beneficiaries). We also used the CMS Medicare Cost Reports submitted by hospice providers (which contain detailed information about providers' costs of providing hospice services) to help verify provider ownership types in the Provider of Services file.

these data to identify unique hospice providers and their ownership types.[6] There were some instances where the information about the provider's ownership type was missing or differed across data sources; in those instances, we supplemented the information with hospice ownership type determinations made by MedPAC.[7] We excluded government-owned hospices from the findings section of this report, as they accounted for less than 5 percent of all hospice providers and generally less than 2 percent of all Medicare hospice beneficiaries during our study period.[8] However, we have included this information in tables in appendix I. We interviewed a non-generalizable sample of hospice providers, provider associations, and researchers who have conducted research on hospice care to obtain information on providing hospice care and possible factors that might explain ownership type differences in beneficiary and provider characteristics.[9] We selected hospices to interview that represented different ownership types, sizes, and geographic areas.

To compare providers' scores on CMS's quality measures and other potential indicators of quality for for-profit and non-profit hospices, we analyzed CMS quality measures data (based on provider-reported quality

[6]We identified unique hospice providers based on a hospice provider's CMS certification number, which serves as an identifier on hospice claims and other data. According to CMS, some providers that are part of a chain may have a single certification number for all of the hospice's locations, whereas other chains may have a separate certification number for each location. Given that a certification number could represent multiple hospice provider locations, our count of hospice providers could be smaller than the total number of hospice provider locations.

[7]We used the CMS Medicare Cost Reports submitted by hospice providers to help determine provider ownership type by verifying ownership type information from the Provider of Services file. As noted, in instances where the ownership type information from the Provider of Services file did not match the ownership type information in the Medicare Cost Reports, we used information from MedPAC to determine the hospice's ownership type.

[8]We excluded providers for which we could not determine ownership type from our analysis (27 providers in 2014, no providers in 2015 and 2016, and 1 provider in 2017). We also excluded hospice beneficiaries that were still enrolled in hospice after the end of 2017 from our analysis of length of stay.

[9]For this report, we received recommendations of hospice providers to interview from provider associations and identified additional providers from Medicare hospice claims data. We also interviewed researchers who have conducted studies on hospice care. We identified these researchers based on recommendations we received from a research organization that conducted hospice studies for CMS, and from one of the researchers we interviewed.

data and caregivers' experience surveys) as well as the CMS data sources described in the previous paragraph. The provider-reported quality data are referred to as the Hospice Item Set data, which are submitted by hospice providers as they provide ongoing care to hospice beneficiaries.[10] The caregivers' experience survey data are obtained using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey, which is completed by hospice beneficiaries' caregivers after the beneficiary has died. To identify potential indicators of quality of care, we interviewed the same non-generalizable sample of researchers described above and reviewed relevant research studies.[11]

To identify and examine opportunities for strengthening CMS's oversight of hospice providers, we interviewed CMS officials, an association representing survey agencies, and the same researchers described above who have studied various aspects of hospice care and oversight, and we reviewed studies on Medicare hospice care as noted above. We reviewed Medicare statutes and regulations, CMS policy manuals and other documents, and CMS summary data for calendar years 2014 through 2017 on hospice enforcement actions. We also examined CMS's oversight and available enforcement remedies for other types of health care providers by interviewing CMS officials and an association representing survey agencies and by reviewing Medicare statutes and regulations and CMS policy manuals. Finally, we compared CMS's oversight to federal standards for internal control.[12]

We assessed the reliability of the CMS data we used for this report by reviewing relevant documentation about the data and the systems that produced them, performing electronic data checks, and interviewing CMS

[10]We did not include another Hospice Item Set measure that looks at whether providers visited hospices within a certain period of time before death. While this measure was finalized in 2017, it had not yet met CMS's public reporting readiness standards at the time we conducted our analyses. For purposes of this report, we refer to this measure as one that CMS is developing.

[11]We identified research studies through a search of several databases, including ProQuest, of peer-reviewed studies, using terms such as "hospice," "live discharge," and "Medicare payment" and restricted our search to studies published in 2013 or later.

[12]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 oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

officials. Based on these steps, we determined the data were sufficiently reliable for the purposes of our reporting objectives.

We conducted this performance audit from May 2018 to October 2019 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 Eligibility and Coverage

To be eligible for the Medicare hospice benefit, an individual must be eligible for Medicare Part A (which covers inpatient care) and be medically certified as having a terminal illness with a life expectancy of 6 months or less if the illness runs it normal course. For individuals to receive care from a Medicare-approved hospice program, they must elect the hospice benefit by signing a statement indicating they are waiving their rights to Medicare payment for services related to curative treatment of their terminal illness.

When enrolling in Medicare hospice care, beneficiaries can receive several different types of services in various settings. Most hospice beneficiaries receive hospice care in their own home, but they can also receive care in other settings, such as a nursing home, assisted living facility, hospice facility, or hospital. 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 caregiver(s) to develop a plan of care that addresses the physical, psychosocial, spiritual, and emotional needs of the beneficiary, family members, and caregiver(s). 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.

Although hospice care is designed for beneficiaries with a life expectancy of 6 months or less, beneficiaries can receive hospice care beyond 6 months if they continue to meet hospice eligibility requirements. In addition, beneficiaries can disenroll from the hospice benefit at any time and re-enroll in hospice care at a later time.

Medicare Hospice Payment

CMS pays hospices based on the level of hospice care provided to beneficiaries on a given day. There are four levels of hospice care, which are paid at either a daily rate or an hourly rate depending on the location and intensity of services provided. (See table 1.) Each care level has a payment rate that is adjusted for geographic differences in wages, and CMS updates these payment rates annually. The most common level of care is called routine home care (accounting for 98 percent of all Medicare hospice care in 2017), and hospices receive the routine home care payment daily rate regardless of whether beneficiaries receive any services on a given day. In addition, CMS imposes two payment limitations (referred to as caps) on Medicare payment for hospice services—one that limits a hospice's number of inpatient days and one that limits a hospice's total Medicare payments in a given year.

Table 1: Medicare Hospice Level-of-Care Payment Rates and Percentage of Total Beneficiary Days, 2017

	Description	2017 payment rate	2017 percentage of Medicare hospice days
Routine home care	Provided on a routine day in which none of the other levels of care are provided. -- Days 1-60	$190.55	98.0%
	Provided on a routine day in which none of the other levels of care are provided. -- Days 61+	$149.82	
	Service intensity add-on payment for direct patient care furnished by a registered nurse or social worker during the last 7 days of a beneficiary's life. This is paid in addition to the routine home care daily rate.	$40.19 per hour for a minimum of 15 minutes per day up to a maximum of four hours per day.	
Continuous home care	Provided during a period of beneficiary crisis to manage the beneficiary at home. A minimum of 8 hours and as much as 24 hours of nursing care or nursing and aide care must be provided on a given day to qualify for this payment level. Care must be predominantly nursing care.	$40.19 per hour	0.2%
Inpatient respite care	Limited, short-term, intermittent inpatient care to allow the beneficiary's caregiver to rest and be relieved from caregiving.	$170.97	0.3%
General inpatient care	Short-term inpatient care to treat beneficiary's symptoms that cannot be managed in another setting.	$734.94	1.4%

Sources: GAO analysis of Centers for Medicare & Medicaid Services' information; Medicare Payment Advisory Commission | GAO-20-10

Notes: CMS adjusts the payment rates shown in this table for geographic differences in wages when making payments to hospice providers. Hospice providers that fail to report required quality data to CMS receive a 2-percentage-point reduction to their annual payment updates. In fiscal year 2017, instead of a 2.1 percent increase under the annual payment update, providers not reporting required data received a 0.1 percent increase. In July 2019, CMS announced changes to payment rates to more accurately align Medicare payments with the costs of providing care. These changes will take effect in fiscal year 2020.

Hospice Quality Reporting Program

In response to requirements in the Patient Protection and Affordable Care Act, CMS established the Hospice Quality Reporting Program, which currently includes two sets of data to assess the quality of hospice providers' care; CMS publishes these data on its Hospice Compare

website.[13] Medicare hospice providers are required to submit these data to CMS for all patients regardless of payer source (e.g., Medicare, Medicaid, or private insurance). The two data sets are the following:

Provider-reported quality measure data. This set of data (which CMS refers to as the Hospice Item Set) is used to calculate a hospice provider's performance on quality measures, which include seven measures that reflect the percentage of all hospice patients' stays where the provider completed various key care processes, such as screening patients for pain and shortness of breath. CMS also recently implemented an eighth measure, called the composite measure, which calculates the percentage of patients' hospice stays in which the hospice provider completed all seven care process quality measures.

Caregivers' experience survey data. This set of data (referred to as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey) is a national survey that captures, from the caregiver's (family member or friend) perspective, the patient's experience with hospice care.[14] The survey includes questions that are used to calculate eight quality measures based on survey responses. For example, one measure scores how well the hospice communicated with the patient's family.

CMS's Hospice Oversight

CMS oversees the quality of Medicare hospice care primarily through inspections—referred to as surveys—which are conducted by state survey agencies contracted by CMS or CMS-approved national private

[13]The Patient Protection and Affordable Care Act required the Secretary of Health and Human Services to establish hospice provider quality reporting requirements and to make these data available to the public on CMS's website. Pub. L. No. 111-148, § 3004(c), 124 Stat. 119, 370 (2010) (codified at 42 U.S.C. § 1395f(i)(5)). This Act also required that CMS provide hospice programs the opportunity to review these data prior to publication on CMS's website. Starting in fiscal year 2014, any hospice provider that fails to submit required data receives a 2-percentage-point reduction in its annual payment update.

[14]This is a national survey of Medicare hospice patient caregivers that is conducted monthly. Some hospice providers are exempt from participation in the survey, including if they have less than 50 survey-eligible caregivers in a year, or started operating as a hospice provider within the year that the survey is fielded. Providers that are not exempt for these reasons are required to participate and failing to do so may result in a 2-percentage-point reduction in the payment increases for the reporting period's fiscal year.

accrediting organizations.[15] These surveys are used to determine whether the hospice is in compliance with federal health and safety requirements detailed in Medicare's hospice conditions of participation.[16] A hospice must be in compliance with these conditions to participate in the Medicare program.[17] Medicare's hospice conditions of participation include requirements related to patient care and organizational environment (e.g., the hospice must organize, manage, and administer its resources to provide necessary care). Each condition of participation is composed of standards associated with the condition, and a standard may have associated sub-components. For example, the "patient's rights" condition includes standards such as "notice of rights and responsibilities" and "rights of the patient." The "rights of the patient" standard includes sub-components, such as the patient has the right to receive effective pain management and symptom control.

There are three main types of survey inspections—an initial certification survey when a provider first seeks to participate in Medicare; a re-certification survey to ensure ongoing compliance; and surveys to investigate complaints or incidents related to federal requirements.[18]

If a hospice is found to be out of compliance with hospice health and safety requirements during a survey, CMS cites the provider for non-

[15]CMS-approved accrediting organizations must demonstrate that their health and safety requirements and survey and oversight processes meet or exceed those used by state survey agencies to determine provider compliance with hospice conditions of participation. For purposes of this report, we describe state survey agency survey processes, which may differ from those of accrediting organizations.

[16]42 C.F.R. §§ 418.52 *et seq.* (2018).These surveys are not to be confused with the caregivers' experience surveys described in the previous section of this report. The caregivers' experience surveys measure quality of care provided whereas the survey inspections of hospice providers determine whether providers are complying with federal health and safety requirements. While distinct, both share the goal of ensuring the health and safety of Medicare hospice beneficiaries.

[17]42 U.S.C. § 1395x(dd)(2); 42 C.F.R. § 418.1 (2018).

[18]The Improving Medicare Post-Acute Care Transformation Act of 2014 mandated that hospices be re-certified by survey every 3 years beginning April 6, 2015, through September 30, 2025. Pub. L. No. 113-185, § 3, 128 Stat. 1952, 1968 (2014) (codified at 42 U.S.C. § 1395x(dd)(4)(C)). According to CMS officials, before this change the survey interval was 7 years with a targeted sample of 5 percent of hospices to be surveyed every 6 years. Complaints are submitted by beneficiaries, their family members or caregiver, health care providers, and other sources. Incidents are reported by providers.

compliance—referred to as a deficiency. These deficiencies are categorized at one of two levels:

Condition-level deficiencies. These deficiencies are the most serious. A condition-level deficiency 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.[19] When a hospice provider is cited for a condition-level deficiency, CMS places the provider on a 90-day termination track (or 23 days if the situation is determined to pose "immediate jeopardy" to beneficiaries) within which the provider must correct the issue(s) and the correction must be confirmed via a follow-up survey visit.[20] If this does not happen within 90 days of the survey date, CMS terminates the hospice's Medicare provider agreement; termination is an enforcement remedy CMS uses to ensure compliance.

Standard-level deficiencies. These deficiencies are less serious. A hospice provider that has a standard-level deficiency can be certified or re-certified only if the provider has submitted an acceptable plan of correction for achieving compliance within a reasonable period of time.[21] According to CMS officials, standard-level deficiencies must also have follow-up to ensure correction, although the type of follow-up depends on the nature of the deficiency. If a standard-level deficiency is very minor and does not place any beneficiaries at risk, the follow-up may be handled through email or telephone instead of a follow-up visit. According to CMS officials, if a provider fails to submit or implement an acceptable plan of correction within a reasonable period of time acceptable to CMS, the provider is placed on the 90-day termination track noted above.

Despite Treating a Similar Number of Beneficiaries as Non-profits, For-profit

[19]42 C.F.R. § 488.24(b) (2018).

[20]Centers for Medicare & Medicaid Services, *State Operations Manual,* "Chapter 3 – Additional Program Activities," § 3012.

[21]42 C.F.R. § 488.28(a) (2018). A "reasonable" amount of time depends on the nature of the deficiency and the surveyor's judgment regarding the provider's ability to provide adequate and safe care. CMS regulations also provide that ordinarily a provider is expected to achieve compliance within 60 days of being notified of a deficiency. 42 C.F.R. § 488.28(d) (2018).

Providers Received Larger Share of Hospice Payments, Reflecting Differences in Lengths of Stay

For-profit and non-profit hospices served roughly the same percentage of the approximately 1.5 million Medicare hospice beneficiaries in 2017, even though for-profit hospices make up about two-thirds of all hospice providers. According to our analysis of CMS data, for-profit providers treated about 50 percent of those beneficiaries and non-profit providers treated about 48 percent in 2017.[22] This distribution has been about the same in each year from 2014 through 2017. For example, for these years, the percentages of beneficiaries treated by for-profit providers ranged from 48.7 percent to 50.2 percent (see additional details in app. I, table 7).

When comparing the beneficiary populations treated by for-profit and non-profit hospice providers, we found that they generally had similar demographic characteristics. We identified two primary exceptions to this general finding: (1) non-profit hospices had slightly higher percentages of white beneficiaries, and (2) for-profit hospices had a greater proportion of patients enrolled in both Medicare and Medicaid. See table 2 (for more detailed data, see app. I, table 8).

Table 2: Percentage of All Medicare Hospice Beneficiaries by Hospice Provider Ownership Type and Percentage of Beneficiaries by Ownership Type for Certain Demographic Characteristics, 2017

		For-profit providers	Non-profit providers
Number of Medicare hospice beneficiaries served[a]	--	778,267	739,835
Percentage of all Medicare hospice beneficiaries served	--	50.3%	47.8%
Beneficiary age	Under 65 years old	5.0%	4.9%
	65-74 years old	16.0%	17.5%
	75-84 years old	28.8%	28.8%
	85+ years old	50.2%	48.8%
Beneficiary race or ethnicity	Asian	1.4%	1.2%
	Black	10.0%	6.7%

[22]Government-owned hospice providers accounted for the remaining 2 percent of hospice beneficiaries in 2017 but we excluded them from the analysis for the findings section of our report. Detailed information on government-owned hospices is included in appendix I.

		For-profit providers	Non-profit providers
	Hispanic	2.9%	1.4%
	Native American	0.4%	0.3%
	White	83.8%	88.7%
	Other	1.1%	1.1%
	Unknown	0.3%	0.5%
Beneficiary gender	Female	59.8%	57.2%
	Male	40.2%	42.8%
Beneficiaries who are eligible for both Medicare and Medicaid	--	27.0%	20.2%
Beneficiaries who were previously enrolled in Medicare Advantage[b]	--	35.9%	34.1%

Source: GAO analysis of Medicare hospice data on beneficiaries, providers, and claims. | GAO-20-10

Note: Government-owned hospice providers accounted for the remaining 1.9 percent of hospice beneficiaries in 2017 but are not included in this analysis.

[a]The number of Medicare hospice beneficiaries served includes beneficiaries that received hospice care from more than one hospice provider, which represented about 3.4 percent of beneficiaries in 2017. As a result, the number of beneficiaries served includes some beneficiaries more than once.

[b]This percentage is based on beneficiaries who were enrolled in Medicare Advantage for at least one month in the year in which the beneficiary received hospice care. Medicare Advantage does not pay for hospice care. Beneficiaries who qualify for hospice care while enrolled in Medicare Advantage receive such care through traditional Medicare.

While beneficiary demographic characteristics were generally similar, we found differences in beneficiary diagnoses between for-profit and non-profit hospices.[23] Specifically, for-profit hospices had, on average, a greater percentage of patients with non-cancer diagnoses—77 percent of for-profit hospice beneficiaries compared to 69 percent of non-profit hospice beneficiaries in 2017.

Our analysis found that for-profit providers received a higher proportion of Medicare hospice payments than did non-profit providers. For 2017, about $10.4 billion (58 percent) of the $17.9 billion dollars in Medicare payments were made to for-profit providers and $7.2 billion (40 percent) of payments were to non-profit providers. Our analysis found this same pattern in each year from 2014 through 2017.

One reason for-profit hospices received a higher portion of Medicare hospice payments for the period we reviewed is because (as previously

[23]Beneficiaries may have been diagnosed with other conditions as well but the primary diagnosis is what qualified the beneficiaries to receive hospice care, which is the diagnosis we used for our analysis.

noted) they had, on average, a greater percentage of beneficiaries with non-cancer diagnoses, and we found non-cancer beneficiaries, on average, had longer lengths of stay. (See table 3.) Since hospices are typically paid a set amount per day of a hospice stay, longer stays generally result in higher payments. Beneficiaries with non-cancer diagnoses can often have longer lengths of stay compared to other beneficiaries because the progression of these diseases (such as dementia) can be harder to predict; this may result in beneficiaries being enrolled in hospice earlier than appropriate (meaning that their projected life expectancy may actually be longer than 6 months). For instance, one study noted that dementia beneficiaries' decline may include periods of stabilization where their health stays the same or even improves, which differs from a constant and predictable decline in most beneficiaries with terminal cancer.[24]

There are likely other factors beyond a greater percentage of beneficiaries with non-cancer diagnoses that contributed to for-profit providers' higher portion of Medicare hospice payments. We found that for-profit providers had, on average, longer lengths of stay for both cancer and non-cancer beneficiaries compared to non-profit providers. (See table 3.) For example, non-cancer beneficiaries at for-profit providers had an average length of stay of 108 days, while non-cancer beneficiaries at non-profit providers had an average length of stay of 67 days. This suggests other factors besides beneficiary diagnosis contributed to longer average length of stay for for-profit providers. (For more detailed beneficiary diagnosis data from 2014 to 2017, see app. I, table 9.)

Table 3: Percentage of Medicare Hospice Beneficiaries by Hospice Provider Ownership Type for Beneficiary Diagnosis, and Average Length of Hospice Stay by Hospice Provider Ownership Type, 2017

		For-profit providers	Non-profit providers
Beneficiary diagnosis	Cancer	23.2%	31.4%
	Non-cancer	76.8%	68.6%
Average length of hospice stay	Cancer	55 days	44 days
	Non-cancer	108 days	67 days

Source: GAO analysis of Medicare hospice data on beneficiaries, providers, and claims. | GAO-20-10

[24]S. Wladkowski, "Dementia Caregivers and Live Discharge from Hospice: What Happens When Hospice Leaves?" *Journal of Gerontological Social Work*, vol. 60, no. 2 (2017): p. 138-154.

Note: We used the Agency for Healthcare Research and Quality listing of cancer diagnoses to classify data on beneficiaries' diagnoses as cancer or non-cancer. Non-cancer diagnoses include diagnoses that are not classified as cancer, such as Alzheimer's disease and chronic obstructive pulmonary disease.

For-profit and Non-profit Providers Scored Similarly on CMS's Quality Measures, though Performance Varied on Other Indicators of Quality

For-profit and non-profit hospice providers had similar scores on CMS's current quality measures (provider-reported measures and caregivers' experience measures assessed through a survey of the beneficiaries' caregiver). CMS uses these measures to assess the quality of care provided by hospices. In addition to CMS's current quality measures, researchers we interviewed noted that there are other care indicators that can also be used to assess the quality of care provided by hospices. According to CMS documents, CMS is working to account for other care indicators by developing additional quality measures. We assessed hospice providers' performance on these indicators and found that performance varied between for-profit and non-profit hospices.

For-profit and Non-profit Hospices Had Similar Scores on CMS's Current Quality Measures, Though For-Profits Were More Often Among Subset with Lowest Scores on Certain Measures

Our review of CMS data found that for 2017, both for-profit and non-profit hospices, on average, had similar scores on the seven quality measures that are provider-reported and that CMS currently uses to assess the quality of hospice care.[25] (See table 4.) For six of the seven measures, for-profit and non-profit hospices had average scores of 94.7 percent or better.

[25]These data were not available for all hospice providers; our analysis of CMS quality measure data was for the 3,449 hospice providers that submitted data on provider-reported quality measures.

Table 4: Average Centers for Medicare & Medicaid Services (CMS) Provider-Reported Quality Measure Scores by Hospice Provider Ownership Type, 2017

Quality measure and description	For-profit average score	Non-profit average score
Beliefs and values – the percentage of patient stays with documentation of a discussion of spiritual/religious concerns or documentation that the patient and/or caregiver did not want to discuss spiritual/religious concerns	94.7	96.9
Dyspnea screening – the percentage of patient stays during which the patient was screened for dyspnea—shortness of breath—during the initial nursing assessment	97.8	98.8
Dyspnea treatment – the percentage of patient stays during which the patient screened positive for dyspnea and received treatment within 1 day of the screening	95.8	96.7
Pain screening – the percentage of patient stays during which the patient was screened for pain during the initial nursing assessment	95.4	96.9
Pain assessment – the percentage of patient stays during which the patient screened positive for pain and received a comprehensive assessment of pain within 1 day of the screening	86.3	86.2
Treatment preferences – the percentage of patient stays with chart documentation that the hospice discussed (or attempted to discuss) preferences for life sustaining treatments	98.6	99.4
Patients treated with an opioid who are given a bowel regimen – the percentage of patient stays in which the patient was treated with an opioid and offered/prescribed a bowel regimen or documentation of why this was not needed	95.5	96.7

Source: GAO analysis of CMS's hospice quality measures data. | GAO-20-10

Notes: Our analysis only includes the 3,449 hospice providers that submitted data on CMS's quality measures.

Providers are required to include data reported to CMS on all hospice patients regardless of payer source (e.g., Medicare, Medicaid, or private insurance) and these data are used to calculate a hospice provider's performance.

We also found that for-profits and non-profits had similar scores (83.6 percent and 87.0 percent, respectively) on a new composite measure that CMS implemented in 2017. This composite measure was designed to provide a more comprehensive evaluation of the hospice's care by determining whether the hospice provider completed all of the applicable parts of hospice care that are measured by the seven quality measures.[26] When looking at the subset of providers with the lowest scores on the composite quality measure, we found that for-profit hospices were more often in this subset, even when accounting for differences in the number of for-profit and non-profit providers:

- For the composite measure, there were 329 providers (261 for-profits and 68 non-profits) in the 10th percentile of scores or lower, meaning that the providers had a composite measure score of 64.3 percent or

[26]The composite measure calculates the percentage of beneficiaries' hospice stays in which the hospice provider completed all seven care process quality measures.

lower. Among these providers, we found that for-profits were more likely to be within this grouping, with about 12 percent of all for-profit providers having scores in the 10th percentile or lower compared to 6 percent of all non-profit providers.

- We also assessed the subset of these 329 providers that had composite measure scores below 50 percent, meaning that they only completed all of CMS's seven quality measures for half or fewer of the beneficiaries they treated. We found that 130 providers (112 for-profits and 18 non-profits) had scores below 50 percent on this measure. These providers treated over 24,000 beneficiaries.

In addition to the provider-reported quality measures, CMS also uses the caregivers' experience survey to assess quality of care. We analyzed CMS data on caregivers' experience surveys for 2016 to 2017 and found that caregivers' reported experience with hospice care was generally similar for both for-profits and non-profits.[27] The survey assesses care in a number of areas, such as communication, training, and help with pain and symptoms. See table 5 (for more detailed data, see app. I, table 10).

Table 5: Average Percentage of Hospices' Caregiver Survey Respondents Who Provided a Given Response, by Hospice Provider Ownership Type, 2016-2017

Response by caregivers for each measure	For-profit average percentage	Non-profit average percentage
Hospice team always communicated well	79.1	81.8
Hospice team always provided timely care	76.7	79.4
Hospice team always treated patient with respect	89.7	91.6
Hospice team provided right amount of emotional and religious support	88.8	90.4
The patient always got the help they needed for pain and symptoms	74.1	76.4
Caregiver definitely received the training they needed	74.0	76.7
Caregiver rated the hospice agency at a 9 or 10 (10 being the best hospice care possible)	79.0	82.5
Caregiver would definitely recommend the hospice	82.4	87.3

Source: GAO analysis of Medicare caregivers' experience with hospice care survey data. | GAO-20-10

Notes: CMS provides caregivers' experience data based on a two-year (or eight quarter) period for providers that have at least 30 completed surveys during that time period. As a result, the data above

[27]These data were not available for all hospice providers; our analysis of CMS caregivers' experience survey quality measure data was for the 2,832 hospice providers that had data for the caregivers' survey.

are for calendar years 2016 and 2017 combined. CMS reports scores on the caregivers' experience survey within three categories (top scores, middle scores, and bottom scores), and the responses and average scores included above are based on the percentage of caregivers who selected responses associated with the top scores. We also analyzed scores among the bottom category of responses and found the same pattern. These data were not available for all hospice providers; our analysis of CMS caregivers' experience survey quality measure data was for the 2,832 hospice providers that had data for the caregivers' survey.

Although for-profit and non-profit providers' average scores on the caregivers' experience survey were generally similar, we found that for-profit providers were more often among those providers with the lowest scores on certain caregivers' experience measures than were non-profit providers. For example, on the rating measure that asks caregivers to give an overall rating of the hospice, 290 providers (248 for-profit providers and 42 non-profits) had scores at the 10th percentile or lower, meaning that their score was 72 percent or lower. For this measure, lower scores mean that fewer caregivers provided a rating of 9 or 10 on a 10-point scale, with 10 being the highest possible rating. We found that 15 percent of for-profit providers were among providers with scores in the 10th percentile or lower compared to 4 percent of non-profit providers.

Performance Varied between For-profit and Non-profit Hospices for Other Indicators of Quality Identified by Researchers

We used Medicare claims data to calculate certain measures researchers told us could be indicators of quality of care in hospice settings. (As noted previously, CMS is working to account for other care indicators by developing additional quality measures.) These indicators fall into two categories: (1) the number of beneficiaries discharged prior to death (often referred to as the live discharge rate) and (2) provider visits to provide medical and emotional support to the beneficiary and caregivers near the end of a beneficiary's life. Researchers told us that such measures can fill gaps in assessing the quality of care provided by hospices, and show greater variability across hospices than CMS's current quality measures; as previously noted, our data analysis found that providers' quality measure scores were generally very high.

Live Discharges

According to researchers we interviewed and studies we reviewed, some discharges from hospice care prior to death should be expected because, for example, patients change their mind about receiving hospice care or their condition improves and they are no longer eligible for hospice care.

However, a high live discharge rate could in some cases be an indicator of poor quality of care provided or of provider misuse of the benefit, in that they may be enrolling beneficiaries who are not eligible for hospice.[28] See text box.

Live Discharges

In some cases, a beneficiary may be discharged alive from hospice care prior to their death. This could be for reasons unrelated to the quality of care provided. For example, beneficiaries may reconsider their decision to start palliative treatment, and therefore leave hospice care to re-start curative treatments.

In other instances, a live discharge may indicate quality of care issues. For example, a beneficiary may be unhappy with the quality of care she is receiving from her hospice provider and therefore she leaves that hospice provider to seek treatment from a different hospice provider. Given the various reasons for live discharges, we expect that hospices will have some live discharges, but interpret a high rate of live discharges as potentially suggestive of quality of care issues.

Source: GAO summary of selected studies, reports, and CMS documents on hospice care | GAO-20-10

We found that for-profits had higher rates of live discharges than non-profits, with 22.1 percent of beneficiaries served by for-profits being discharged alive compared to 12.0 percent of beneficiaries served by non-profits in 2017. This disparity remained true after accounting for whether beneficiaries had a cancer or non-cancer diagnosis. (See table 6; for more detailed data from 2014 to 2017, see app. I, table 11.) We found that 472 hospice providers (462 for-profit and 10 non-profit providers) had live discharge rates of 50 percent or more in 2017, meaning that half or more of their beneficiaries were discharged from hospice care prior to death. These providers provided care to about 6 percent of all beneficiaries discharged alive in 2017.

Table 6: Percentage of Medicare Hospice Beneficiaries Discharged Alive by Hospice Provider Ownership Type and Beneficiary Diagnosis, 2017

		For-profit providers	Non-profit providers
Percentage of beneficiaries discharged prior	Cancer	15.2%	9.1%

[28]According to MedPAC, hospices are expected to have some rates of live discharge such as the beneficiary may disenroll as they change their mind about receiving hospice care, the beneficiary's condition improves and they no longer meet hospice eligibility criteria, or the beneficiary may change hospice providers or move out of the provider's service area.

CMS is working on developing a quality measure related to potentially avoidable live discharges. The goal of the measure is to identify hospices that have notably higher rates of live discharges followed shortly by death or acute care utilization, when compared to other hospices.

		For-profit providers	Non-profit providers
to death	Non-cancer	24.2%	13.4%

Source: GAO analysis of Medicare hospice data on beneficiaries, providers, and claims. | GAO-20-10

Notes: We used the Agency for Healthcare Research and Quality listing of cancer diagnoses to classify data on beneficiaries' diagnoses as cancer or non-cancer. Non-cancer diagnoses include diagnoses that are not classified as cancer, such as Alzheimer's disease and chronic obstructive pulmonary disease. In this analysis, we included beneficiaries that were discharged alive and those that died while enrolled in hospice care. Since some beneficiaries were discharged alive and then later re-enrolled in hospice care and subsequently died while enrolled in hospice care, beneficiaries were sometimes counted more than once for the purposes of this analysis.

Visits at the End of Life

According to researchers we interviewed and one of the studies we reviewed, provider visits near the end of a hospice beneficiary's life are critical to providing quality care, including for emotional support and for training the beneficiary's family members or other caregivers on the signs and process of dying. Assessing the number of visits near the end of life may provide insight into the quality of a hospice provider's care; fewer visits in that time period could indicate poor quality of hospice care. CMS is currently developing a quality measure that assesses the frequency of provider visits at the beneficiary's end of life.[29]

When analyzing CMS claims data, we found that for-profit and non-profit hospices, on average, provided a similar number of provider visits (such as nurse, doctor, social worker, or hospice aide visits) within the last 7 days of a beneficiary's life. Specifically, in 2017, for-profits and non-profits both averaged about 6 provider visits within the last 7 days of life.[30] We also looked at the average percentage of hospice beneficiaries who received different types of provider visits either within the last 3 days of life or last 7 days of life (consistent with CMS's new quality measure) and found performance varied among for-profit and non-profit providers:

[29]CMS's new measure is referred to as "hospice visits when death is imminent" and consists of two measurements: (1) the percentage of patients receiving at least one visit from registered nurses, physicians, nurse practitioners, or physician assistants in the last 3 days of life; and (2) the percentage of patients receiving at least 2 visits from medical social workers, chaplains or spiritual counselors, licensed practical nurses, or hospice aides in the last 7 days of life. CMS began collecting data on this measure on April 1, 2017.

[30]This analysis is based on any visit from a variety of providers, including registered nurses, licensed practical nurses, physicians, nurse practitioners, medical social workers, chaplains or spiritual counselors, or hospice aides.

- 77 percent of for-profit beneficiaries and 85 percent of non-profit beneficiaries received at least one visit from registered nurses, physicians, or nurse practitioners in the last 3 days of life.
- 68 percent of for-profit beneficiaries and 57 percent of non-profit beneficiaries received at least two visits from medical social workers, chaplains or spiritual counselors, licensed practical nurses, or hospice aides in the last 7 days of life.

We also found more for-profits than non-profits among a subset of hospices that did not provide any visits during the last 3 or 7 days of life in 2017. Specifically, our analysis shows that 83 hospice providers (80 for-profits and 3 non-profits) did not provide any visits in 2017 from registered nurses, physicians, or nurse practitioners in the beneficiaries' last 3 days of life. This means that all of the 800 hospice beneficiaries treated by these providers did not receive these types of provider visits at the end of life. In addition, we found that 58 providers (55 for-profits and 3 non-profits) did not provide any visits from medical social workers, chaplains or spiritual counselors, licensed practical nurses, or hospice aides in the last 7 days of life in 2017; all of the 613 beneficiaries treated by these providers did not receive these specific provider visits at the end of life.

Opportunities Exist to Strengthen CMS Oversight through Increased Use of Information in Survey Process and Expanded Statutory Authority for Enforcement

CMS Could Strengthen Oversight of Hospice Providers by Using Additional Information to Enhance the Survey Process

In our review of CMS's oversight of hospice providers, we found CMS does not instruct surveyors to review, prior to surveying hospice providers, providers' performance on CMS quality measures (those based on provider-reported quality data or caregivers' experience surveys) or other indicators of quality that could identify potential areas of concern. CMS issues guidance that surveyors use when conducting surveys to assess a hospice provider's compliance with federal health and safety requirements. According to this guidance, surveyors are to prepare for hospice surveys by reviewing documents of record including licensure records, previous survey findings and complaints, media reports, and

other publicly available information about the provider. A representative for an association representing state surveyors confirmed that this is the type of information surveyors typically review prior to a hospice provider survey. However, according to CMS officials and the surveyor association, CMS does not instruct surveyors to review other information such as providers' performance on CMS quality measures or other indicators of quality that surveyors could use to identify potential areas of concern that they could focus on more closely during a survey. For example, it might be helpful for surveyors to know if a hospice provided no visits during beneficiaries' last days of life. According to CMS officials, CMS does not use such information to target hospices for additional survey review.

Several studies we reviewed and researchers we interviewed noted CMS could strengthen its survey process by incorporating additional information into the survey process, such as information on how hospice providers perform on CMS quality measures or other potential indicators of quality.[31] For example, one study suggested that hospices with poor reported beneficiary experiences based on caregivers' experience survey data could be identified for more frequent surveys and that such information could be used to identify care processes for closer review during surveys.[32] Another study we reviewed concluded that claims-based measures could help guide surveyors to more closely review key processes of care to ensure Medicare beneficiaries receive high quality hospice care.[33] In addition, a researcher we interviewed suggested when claims data show no visits during the last 2 days of life, the survey team could interview the deceased patients' families to see if there was any harm done by the lack of visits at the end of life. And, in July 2019, the Department of Health and Human Services' Office of the Inspector General (HHS OIG) reiterated recommendations from prior HHS OIG

[31]M. Plotzke, J. Teno, P. Gozalo, T. Christian, "Population-Based Measures from Administrative Data to Guide Efforts to Examine and Improve the Quality of Hospice Care," *Journal of Pain and Symptom Management,* vol. 53, no. 2 (2017): p. 415-416. Department of Health and Human Services, Office of Inspector General, *Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio,* OEI-02-16-00570 (Washington, D.C.: July 2018). R. Anhang Price, L. Parast, A. Haas, J. Teno, and M. Elliott, "Black and Hispanic Patients Receive Hospice Care Similar to that of White Patients When in the Same Hospices," *Health Affairs,* vol. 36, no. 7 (2017): p.1283-1290.

[32]Price, Parast, Haas, Teno, and Elliott, "Black and Hispanic Patients," p.1289.

[33]Plotzke, Teno, Gozalo, Christian, "Population-Based Measures," p. 416.

work that CMS analyze claims and deficiency data to identify specific patterns identified by the HHS OIG that could indicate potential issues—such as hospices that infrequently provide physician services—and that CMS instruct surveyors to pay special attention to these areas during surveys.[34]

In contrast to hospice surveys, home health agency surveyors utilize information in addition to survey findings and complaints to identify potential areas of concern.[35] According to CMS officials and the surveyor association we interviewed, home health surveyors review certain CMS quality measures to focus the survey on specific areas of concern or to identify beneficiaries who experienced potential care issues for a more detailed survey review.[36]

According to CMS officials, the agency is considering making changes to the survey process but has not yet made any decisions. CMS officials told us they last updated the survey process in 2010, and since then, they have implemented quality measures for hospice providers (provider-reported measures in 2014 and caregivers' experience survey measures in 2015). They also said that CMS is "currently monitoring the implementation of these programs and considering the potential benefit of incorporating review of the data into the survey process." According to federal standards of internal control, agencies must identify, analyze, and

[34]Department of Health and Human Services, Office of Inspector General, *Hospice Deficiencies Pose Risks to Medicare Beneficiaries,* OEI-02-17-00020 (Washington, D.C.: July 2019) and OEI-02-16-00570. CMS did not concur with the recommendation to analyze claims data, stating that surveyors do not determine the medical necessity of the services provided and are not an extension of the audit process. CMS also did not concur with the recommendation to analyze deficiency data stating that surveyors ensure all deficiencies are corrected and review previous complaints and survey findings before conducting a survey.

[35]Home health agencies provide care to beneficiaries in their homes or in residential care facilities and assist with monitoring health status and providing individualized health care. Home health services include skilled nursing care, physical therapy, occupational therapy, speech-language pathology services, medical social services, home health aide services, and medical supplies (such as catheters).

[36]According to CMS officials, home health agency quality measures are more numerous and diverse than hospice quality measures in part because the home health agency quality program is older and more developed than the hospice quality program. For example, CMS officials told us that home health agency quality measures include beneficiary outcome measures (such as hospitalizations or emergency department use), which officials said may provide more information to surveyors than the current hospice quality measures that focus on whether providers completed certain care processes, such as screening patients for pain or shortness of breath.

respond to risks related to achieving objectives.[37] By not utilizing additional information in the survey process that would allow it to identify providers and areas where risk of noncompliance is greatest, CMS is missing an opportunity to strengthen its ability to identify and respond to such risks and ensure the quality of care that hospice beneficiaries receive.

CMS Has Limited Enforcement Remedies Due to Lack of Statutory Authority, Which Could Restrict Its Ability to Ensure Compliance

CMS is limited to one hospice enforcement remedy—termination of the Medicare provider agreement. By law, to qualify for payment under the Medicare program, hospice providers must meet the program's conditions of participation.[38] If the agency finds a provider is not complying with the program's conditions of participation, CMS may terminate the provider's participation in the program.[39] In the Medicare program, termination of a provider is the most significant action CMS can take to address provider non-compliance. As a result, CMS generally only terminates a hospice provider on the basis of a deficiency when the provider fails to correct a condition-level deficiency (the most severe) within the required time frame.[40] Our review of CMS hospice survey data found termination happens rarely. Specifically, 19 hospices were involuntarily terminated

[37]GAO-14-704G.

[38]42 U.S.C. § 1395x(dd)(2); 42 C.F.R. § 418.1 (2018).

[39]42 C.F.R. § 489.53(a)(3) (2018).

[40]Hospice providers must comply with federal health and safety requirements detailed in Medicare's hospice conditions of participation. A condition-level deficiency is one in which a provider is out of compliance with one or more standards, and the deficiencies are of such character as to substantially limit the provider's capacity to furnish adequate care or that adversely affect the health and safety of patients. For example, according to CMS officials, a hospice provider was cited for a condition-level deficiency when the survey team reviewed a sample of five patient care files and found the hospice provider had failed to provide effective pain management for one of the five patients.

CMS may terminate a Medicare provider agreement for reasons unrelated to a deficiency, such as violations of the provider agreement terms.

from 2014 through 2017.[41] This is less than half of 1 percent of the total number of hospices operating during this time period.

In contrast to hospice care, where CMS's enforcement authority is limited to termination, Congress has given the agency authority to impose additional enforcement remedies for other provider types.[42] Additional statutory and regulatory penalties for home health agencies and nursing homes include civil money penalties, denial of payment for all new Medicare and Medicaid admissions, and imposition of training requirements for situations where it is determined that education will likely lead to provider compliance (referred to as directed in-service training).[43] Such remedies, if available, could enable the agency to more effectively address a broader range of hospice risks. For example, additional remedies could be used in situations that warrant a remedy other than termination or that could further incentivize providers to comply with health and safety requirements or improve their quality of care. According to federal standards of internal control, agencies must identify, analyze, and respond to risks related to achieving objectives.[44] Because CMS lacks the authority to establish such additional remedies, the agency's ability to respond to risks and ensure quality of care for beneficiaries is limited.

The HHS OIG and one researcher we interviewed have recommended CMS seek statutory authority to establish additional enforcement remedies for hospices, explaining that less severe remedies could help address performance problems that may not merit termination and incentivize agencies to improve quality of care.[45] CMS agreed with this

[41]These terminations could include hospice providers that were terminated because they failed to meet health and safety requirements (i.e., conditions of participation) or providers terminated because they failed to meet provider agreement terms (e.g., requirements not related to conditions of participation, such as billing and payment requirements). Also, these terminations exclude hospice providers that voluntarily terminated their provider agreement because of the risk of involuntary termination.

[42]42 U.S.C. §§ 1395i-3(h)(2), 1395bbb(f)(1)(A). In addition, states may have their own enforcement remedies.

[43]See 42 C.F.R. part 488, subparts F, J (2018).

[44]GAO-14-704G.

[45]Department of Health and Human Services, Office of Inspector General, *Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care,* OEI-02-16-00491 (Washington, D.C.: March 2016).

recommendation in March 2016 and stated it would consider submitting a request that would seek legislative authority to establish additional enforcement remedies through the President's annual budget proposal to Congress. In a July 2018 HHS OIG report, the HHS OIG again recommended CMS seek this authority.[46] CMS neither agreed nor disagreed with this recommendation and stated again that it would consider this recommendation when developing the agency's proposals for the President's annual budget. However, a request for such legislative authority was not included in the President's fiscal year 2017, 2018, or 2019 budget proposals. The HHS OIG reiterated this recommendation in two July 2019 reports.[47]

Conclusions

Since 2000, the number of Medicare hospice beneficiaries has almost tripled to nearly 1.5 million in fiscal year 2017. In addition, the number of hospice providers has doubled. Given this growth, it is imperative that CMS's oversight of the quality of Medicare hospice care keeps pace with changes so that the agency can ensure the health and safety of these terminally ill beneficiaries. While recent steps have been taken to strengthen CMS's hospice quality oversight, including the requirement that hospices be re-certified every 3 years and CMS's ongoing development of new quality measures, we identified additional opportunities to strengthen CMS's oversight. Specifically, our review found that CMS could strengthen oversight by using additional information—based on currently available data—to identify potential quality issues that could focus and enhance the survey process. We also found that CMS's lack of authority to establish additional enforcement remedies before termination, which CMS rarely uses, limits its ability to ensure hospice providers' compliance with health and safety requirements and quality of care for beneficiaries.

[46]Department of Health and Human Services, Office of Inspector General, OEI-02-16-00570.

[47]Department of Health and Human Services, Office of Inspector General, OEI-02-17-00020 and *Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm,* OEI-02-17-00021 (Washington, D.C.: July 2019).

Matter for Congressional Consideration

Congress should consider giving CMS authority to establish additional enforcement remedies for hospices that do not meet federal health and safety requirements. (Matter for Consideration 1)

Recommendation for Executive Action

The Administrator of CMS should incorporate the use of additional information, such as quality measures or other information that could identify potential quality of care issues, into its survey process for overseeing hospice providers. (Recommendation 1)

Agency Comments

We provided a draft of this report to HHS for review and comment. HHS provided written comments, which are reprinted in appendix II. HHS concurred with our recommendation. HHS stated that it recognizes that meaningful quality measures can also serve as key indicators of provider quality and it will look into ways to incorporate the use of these data into the hospice survey process. In its comment letter, HHS also noted the importance of monitoring patient safety and quality of care to HHS's hospice oversight efforts and the agency provided an overview of the key efforts it has in place to perform such monitoring. For example, in addition to survey and quality measure requirements, HHS requires hospices to implement a data-driven quality assessment and performance improvement program, intended to have hospices take a proactive approach in improving their performance using objective data. HHS also provided technical comments, which we incorporated into the report as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the CMS administrator, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@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.

Sincerely yours,

James Cosgrove
Director, Health Care

Appendix I: Additional Data on Medicare Hospice Beneficiaries, Providers, and Payments

Table 7: Number and Percentage of Hospice Providers by Ownership Type, Medicare Hospice Beneficiaries Served, and Medicare Payments Received, 2014-2017

		2014		2015		2016		2017	
		Number/ Dollars	Percentage	Number/ Dollars	Percentage	Number/ Dollars	Percentage	Number/ Dollars	Percentage
Hospice providers	For-profit	2,607	64.3%	2,701	65.0%	2,910	67.1%	3,065	69.0%
	Non-profit	1,250	30.8%	1,277	30.7%	1,256	29.0%	1,217	27.4%
	Government	198	4.9%	177	4.3%	170	3.9%	159	3.6%
	Total	**4,055**	**100.0%**	**4,155**	**100.0%**	**4,336**	**100.0%**	**4,441**	**100.0%**
Beneficiaries served[a]	For-profit	668,476	49.0%	691,003	48.7%	721,201	49.1%	771,313	50.2%
	Non-profit	663,441	48.7%	703,200	49.6%	721,281	49.1%	737,336	48.0%
	Government	31,547	2.3%	24,522	1.7%	25,188	1.7%	28,664	1.9%
	Total	**1,363,464**	**100.0%**	**1,418,725**	**100.0%**	**1,467,670**	**100.0%**	**1,537,313**	**100.0%**
Payments received (in millions and rounded to the nearest million)	For-profit	$8,634	57.5%	$9,023	57.2%	$9,550	57.1%	$10,373	58.2%
	Non-profit	$6,107	40.7%	$6,558	41.6%	$6,976	41.7%	$7,206	40.4%
	Government	$277	1.8%	$193	1.2%	$208	1.2%	$248	1.4%
	Total	**$15,018**	**100.0%**	**$15,774**	**100%**	**$16,733**	**100%**	**$17,827**	**100.0%**

Source: GAO analysis of Medicare hospice data on beneficiaries, providers, and claims. | GAO-20-10

Note: Percentages may not sum to 100 percent due to rounding.

[a]The number of Medicare hospice beneficiaries served includes beneficiaries that received hospice care from more than one hospice provider, which represented about 3.3 percent in 2014, 3.3 percent in 2015, 3.4 percent in 2016, and 3.4 percent of beneficiaries in 2017. As a result, the number of beneficiaries served includes some beneficiaries more than once.

Table 8: Number and Characteristics of Medicare Hospice Beneficiaries by Hospice Provider Ownership Type, 2014-2017

		Demographic	2014	2015	2016	2017
For-profit providers	Number of beneficiaries treated[a]	-	676,058	699,150	728,980	778,267
	Age	Under 65 years old	5.4%	5.2%	5.1%	5.0%
		65-74 years old	15.7%	15.9%	16.1%	16.0%
		75-84 years old	28.9%	28.6%	28.7%	28.8%
		85+ years old	50.0%	50.3%	50.1%	50.2%
	Race or ethnicity	Asian	1.2%	1.3%	1.3%	1.4%
		Black	10.0%	10.1%	10.1%	10.0%
		Hispanic	2.8%	2.9%	2.9%	2.9%
		Native American	0.4%	0.4%	0.4%	0.4%
		White	84.4%	84.0%	83.8%	83.8%
		Other	0.9%	1.0%	1.1%	1.1%
		Unknown	0.2%	0.3%	0.3%	0.3%
	Gender	Female	60.4%	60.2%	59.9%	59.8%
		Male	39.6%	39.8%	40.1%	40.2%
	Prior Medicare Advantage enrollment[b]	Medicare Advantage enrollee	30.2%	32.7%	33.6%	35.9%
		Traditional Medicare enrollee	69.8%	67.3%	66.4%	64.1%
	Dual eligibility for Medicare and Medicaid	Dual eligible	26.4%	26.7%	26.9%	27.0%
		Medicare-only	73.6%	73.3%	73.1%	73.0%
Non-profit providers	Number of beneficiaries treated[a]	-	666,633	705,678	723,864	739,835
	Age	Under 65 years old	5.3%	5.2%	5.0%	4.9%
		65-74 years old	17.6%	17.5%	17.6%	17.5%
		75-84 years old	29.5%	28.8%	28.7%	28.8%
		85+ years old	47.6%	48.5%	48.7%	48.8%
	Race or ethnicity	Asian	1.1%	1.1%	1.2%	1.2%
		Black	6.6%	6.6%	6.8%	6.7%
		Hispanic	1.4%	1.3%	1.4%	1.4%
		Native American	0.3%	0.3%	0.3%	0.3%
		White	89.4%	89.3%	88.9%	88.7%
		Other	1.0%	1.0%	1.1%	1.1%
		Unknown	0.3%	0.3%	0.4%	0.5%
	Gender	Female	57.3%	57.5%	57.4%	57.2%
		Male	42.7%	42.5%	42.6%	42.8%

		Demographic	2014	2015	2016	2017
	Prior Medicare Advantage enrollment[b]	Medicare Advantage enrollee	29.7%	31.4%	32.2%	34.1%
		Traditional Medicare enrollee	70.3%	68.6%	67.8%	65.9%
	Dual eligibility for Medicare and Medicaid	Dual eligible	20.2%	20.2%	20.0%	20.2%
		Medicare-only	79.8%	79.8%	80.0%	79.8%
Government-owned providers	Number of beneficiaries treated[a]		31,539	24,516	25,182	28,658
	Age	Under 65 years old	5.6%	5.6%	5.9%	5.6%
		65-74 years old	18.0%	18.6%	18.7%	18.8%
		75-84 years old	30.0%	30.3%	29.9%	29.7%
		85+ years old	46.4%	45.5%	45.5%	46.0%
	Race or ethnicity	Asian	0.7%	0.7%	0.7%	0.7%
		Black	7.0%	6.7%	6.8%	7.2%
		Hispanic	0.9%	0.7%	0.7%	0.8%
		Native American	0.3%	0.4%	0.4%	0.3%
		White	90.2%	90.5%	90.4%	89.8%
		Other	0.6%	0.6%	0.7%	0.7%
		Unknown	0.2%	0.4%	0.3%	0.4%
	Gender	Female	56.5%	56.1%	56.9%	56.2%
		Male	43.5%	43.9%	43.1%	43.8%
	Prior Medicare Advantage enrollment[b]	Medicare Advantage enrollee	26.8%	23.3%	24.3%	28.1%
		Traditional Medicare enrollee	73.2%	76.7%	75.7%	71.9%
	Dual eligibility for Medicare and Medicaid	Dual eligible	24.2%	22.9%	23.4%	23.6%
		Medicare-only	75.8%	77.1%	76.6%	76.4%

Source: GAO analysis of Medicare hospice data on beneficiaries, providers, and claims. | GAO-20-10

Note: Percentages may not sum to 100 percent due to rounding.

[a]The number of Medicare hospice beneficiaries served includes beneficiaries that received hospice care from more than one hospice provider, which represented about 3.3 percent in 2014, 3.3 percent in 2015, 3.4 percent in 2016, and 3.4 percent of beneficiaries in 2017. As a result, the number of beneficiaries served includes some beneficiaries more than once.

[b]This percentage is based on beneficiaries who were enrolled in Medicare Advantage for at least 1 month in the year in which the beneficiary received hospice care. Medicare Advantage does not pay for hospice care. Beneficiaries who qualify for hospice care while enrolled in Medicare Advantage receive such care through traditional Medicare.

Table 9: Percentage of Medicare Hospice Beneficiaries by Hospice Provider Ownership Type for Beneficiary Diagnosis, 2014-2017

		2014	2015	2016	2017
For-profit providers Percentage of beneficiaries by diagnosis	Cancer	24.9%	24.3%	23.9%	23.2%
	Non-cancer	75.1%	75.7%	76.1%	76.8%
Non-profit providers Percentage of beneficiaries by diagnosis	Cancer	33.8%	32.6%	32.2%	31.4%
	Non-cancer	66.2%	67.4%	67.8%	68.6%
Government-owned providers Percentage of beneficiaries by diagnosis	Cancer	33.0%	33.1%	32.0%	31.1%
	Non-cancer	67.0%	66.9%	68.0%	68.9%

Source: GAO analysis of Medicare hospice data on beneficiaries, providers, and claims. | GAO-20-10

Notes: We used the Agency for Healthcare Research and Quality listing of cancer diagnoses to classify data on beneficiaries' diagnoses as cancer or non-cancer. Non-cancer diagnoses include diagnoses that are not classified as cancer, such as Alzheimer's disease and chronic obstructive pulmonary disease.

Table 10: Average Caregivers' Experience Survey Measure Scores by Hospice Provider Ownership Type, 2016-2017

	Caregivers' experience survey measures	Average top box scores (percentages)[a]	Average middle box scores (percentages)[b]	Average bottom box scores (percentages)[c]
For-profit hospice providers' average scores	Hospice team communication	79.1	13.3	7.6
	Hospice team provided timely care	76.7	13.2	10.1
	Hospice team treated patient with respect	89.7	7.7	2.6
	Amount of emotional and religious support provided by the hospice team	88.8	—	11.2
	The patient got the help they needed for pain and symptoms	74.1	15.8	10.1
	Caregiver received the training they needed	74.0	15.8	10.2
	Caregiver rating of hospice agency on 10-point scale with 10 being the best hospice care possible	79.0	15.3	5.7
	Caregiver would recommend the hospice	82.4	12.5	5.1
Non-profit hospice providers' average scores	Hospice team communication	81.8	11.9	6.3
	Hospice team provided timely care	79.4	11.5	9.1
	Hospice team treated patient with respect	91.6	6.4	2.0
	Amount of emotional and religious support provided by the hospice team	90.4	—	9.6
	The patient got the help they needed for pain and symptoms	76.4	14.7	8.9
	Caregiver received the training they needed	76.7	14.8	8.5

	Caregivers' experience survey measures	Average top box scores (percentages)[a]	Average middle box scores (percentages)[b]	Average bottom box scores (percentages)[c]
	Caregiver rating of hospice agency on 10-point scale with 10 being the best hospice care possible	82.5	13.4	4.2
	Caregiver would recommend the hospice	87.3	9.3	3.4
Government-owned hospice providers' average scores	Hospice team communication	84.8	9.8	5.5
	Hospice team provided timely care	83.5	8.9	7.6
	Hospice team treated patient with respect	93.3	5.2	1.5
	Amount of emotional and religious support provided by the hospice team	91.7	—	8.3
	The patient got the help they needed for pain and symptoms	79.0	13.3	7.6
	Caregiver received the training they needed	79.3	13.5	7.2
	Caregiver rating of hospice agency on 10-point scale with 10 being the best hospice care possible	85.7	11.3	3.1
	Caregiver would recommend the hospice	90.3	7.3	2.5

Source: GAO analysis of Medicare caregivers' experience with hospice care survey data. | GAO-20-10

Notes: CMS provides caregivers' experience data based on a 2-year (or eight quarter) period for providers that have at least 30 completed surveys during that time period. As a result, the data above are for calendar years 2016 and 2017 combined. CMS reports scores on the caregivers' experience survey within three categories (top scores, middle scores, and bottom scores). These data were not available for all hospice providers; our analysis of CMS caregivers' experience survey quality measure data was for the 2,832 hospice providers that had data for the caregivers' survey.

[a]In general, the top-box scores represent the percentage of caregivers that selected the response of "always" for the particular measure. For the rating measure, the top-box score represents caregivers that rated the hospice provider as a 9 or 10 on a 10-point scale with 10 being the highest rating. For the recommendation measure, the top-box score represents caregivers that responded that they "would definitely recommend the hospice provider."

[b]In general, the middle-box scores represent the percentage of caregivers that selected the response of "usually" for the particular measure. For the rating measure, the middle-box score represents caregivers that rated the hospice provider as a 7 or 8 on a 10-point scale with 10 being the highest rating. For the recommendation measure, the middle-box score represents caregivers that responded that they "would probably recommend the hospice provider."

[c]In general, the bottom-box scores represent the percentage of caregivers that selected the response of "sometimes" or "never" for the particular measure. For the rating measure, the bottom-box score represents caregivers that rated the hospice provider as a 6 or lower on a 10-point scale with 10 being the highest rating. For the recommendation measure, the bottom-box score represents caregivers that responded that they would "probably not" or "definitely not" recommend the hospice provider.

Table 11: Percentage of Medicare Hospice Beneficiaries Discharged Alive by Hospice Provider Ownership Type and Beneficiary Diagnosis, 2014-2017

		2014	2015	2016	2017
For-profit providers Percentage of beneficiaries discharged prior to death	Cancer	15.0%	15.1%	15.3%	15.2%
	Non-cancer	24.6%	24.1%	24.4%	24.2%
Non-profit providers Percentage of beneficiaries discharged prior to death	Cancer	9.7%	9.3%	9.2%	9.1%
	Non-cancer	14.6%	13.8%	13.8%	13.4%
Government-owned providers Percentage of beneficiaries discharged prior to death	Cancer	10.0%	9.6%	9.1%	9.0%
	Non-cancer	16.5%	15.0%	15.3%	13.9%

Source: GAO analysis of Medicare hospice data on beneficiaries, providers, and claims. | GAO-20-10

Notes: Percentages may not add to 100 due to rounding. We used the Agency for Healthcare Research and Quality listing of cancer diagnoses to classify data on beneficiaries' diagnoses as cancer or non-cancer. Non-cancer diagnoses include diagnoses that are not classified as cancer, such as Alzheimer's disease and chronic obstructive pulmonary disease. In this analysis, we included beneficiaries that were discharged alive and those that died while enrolled in hospice care. Since some beneficiaries were discharged alive and then later re-enrolled in hospice care and subsequently died while enrolled in hospice care, beneficiaries were sometimes counted more than once for the purposes of 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

James Cosgrove
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

SEP 25 2019

Dear Mr. Cosgrove:

Attached are *comments* on the U.S. Government Accountability Office's (GAO) report entitled, "*MEDICARE HOSPICE CARE: Opportunities Exist to Strengthen CMS Oversight of Hospice Providers*" (GAO-20-10).

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

Sincerely,

Sarah Arbes
Acting Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED — MEDICARE HOSPICE CARE: OPPORTUNITIES EXISTS TO STRENGTHEN CMS OVERSIGHT OF HOSPICE PROVIDERS (GAO-20-10)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the U.S. Government Accountability Office (GAO) draft report. HHS is committed to providing Medicare beneficiaries in hospice care with high-quality care.

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

HHS regularly provides training to surveyors to ensure that they are familiar with certification requirements laid out in the hospice conditions of participation. HHS also establishes survey protocols in our guidance to direct the surveyor's attention to certain avenues for investigation in preparation for the survey, in conducting the survey, and in evaluation of the survey findings. Recognizing the importance of utilizing existing provider information in the survey process, HHS's guidance specifically states that surveyors should prepare for hospice surveys by reviewing documents of record including licensure records, previous survey findings and complaints, media reports, and other publicly available information about the provider.[1]

Another important element in incentivizing quality care in hospices and providing important information to patients is through the HHS portfolio of meaningful hospice quality measures. HHS identifies and develops measures that provide a window into hospice care throughout the hospice experience, fit well with the hospice business model, and meet the objectives of the Centers for Medicare & Medicaid Services (CMS) Meaningful Measures initiative. This initiative was launched in 2017, and it identifies high priority areas for quality measurement to improve outcomes for patients, their families, and providers, while also reducing burden on clinicians and providers.

The HHS portfolio of meaningful hospice quality measures are publicly reported on the Hospice Compare website. The Hospice Quality Reporting Program (HQRP) began in FY 2014, and the Hospice Compare website to publicly report these measures became operational in August 2017. Hospice Compare gives consumers, providers, and other stakeholders, valuable quality measurement performance information for all Medicare-certified hospice providers. Providing access to quality information, both now and as the website matures and grows over time, is a high priority for HHS so that beneficiaries have the information they need to make healthcare choices.

[1] State Operations Manual, Chapter 2, Section 2704 – SA Presurvey Preparation, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED — MEDICARE HOSPICE CARE: OPPORTUNITIES EXISTS TO STRENGTHEN CMS OVERSIGHT OF HOSPICE PROVIDERS (GAO-20-10)

HHS has worked to track and improve the quality of data collected through the HQRP, including routinely re-evaluating current measures and identifying several high priority areas for future measure development. In April 2017, HHS began collecting data for two new measures related to the provision of hospice care at the end of life. Such enhancements to the HQRP will allow CMS's quality measurement and improvement efforts to better align with what is most meaningful to patients.

In addition to the survey and quality measure requirements, HHS requires hospices to implement a data-driven quality assessment and performance improvement (QAPI) program.[2] The fundamental purpose of the QAPI condition of participation is to set a clear expectation that hospices take a proactive approach to improve their performance. HHS expects hospices to demonstrate, with objective data, that improvements have taken place in actual care outcomes, processes of care, patient/family satisfaction levels, hospice operations, or other performance indicators.

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 recommendation and HHS' response are below.

GAO Recommendation
The Administrator of CMS should incorporate the use of additional information, such as quality measures or other information that could identify potential quality of care issues, into its survey process for overseeing hospice providers.

HHS Response
HHS concurs with this recommendation. HHS provides guidance to surveyors to prepare for hospice surveys by reviewing documents of record including licensure records, previous survey findings and complaints, media reports, and other publicly available information about the provider. HHS recognizes that meaningful quality measures can also serve as key indicators of provider quality. Quality measure information is available on Hospice Compare as a resource for consumers, providers, and stakeholders, and could also be used by surveyors as part of oversight efforts. We will look into ways to incorporate the use of this meaningful quality measure data into the hospice survey process.

[2] 42 CFR 418.58

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

Page 1

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Director, Health Care

U.S. Government Accountability Office

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Acting Assistant Secretary for Legislation

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Page 2

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Another important element in incentivizing quality care in hospices and providing important information to patients is through the HHS portfolio of meaningful hospice quality measures. HHS identifies and develops measures that provide a window into hospice care throughout the hospice experience, fit well with the hospice business model, and meet the objectives of the Centers for Medicare & Medicaid Services (CMS) Meaningful Measures initiative. This initiative was launched in 2017, and it identifies high priority areas for quality measurement to improve outcomes for patients, their families, and providers, while also reducing burden on clinicians and providers.

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[2] 42 CFR 418.58

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Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

James Cosgrove, (202) 512-7114, cosgrovej@gao.gov

Staff Acknowledgments

In addition to the contact named above, Gregory Giusto, Assistant Director; Christie Enders, Analyst-in-Charge; Todd Anderson, Leia Dickerson, Rob Dougherty, Krister Friday, Barbara Hansen, Jennifer Whitworth, and Chris Wickham made key contributions to this report.

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