National Hospice and Palliative Care Organization

Regulatory Alerts

NHPCO
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CMS Releases Revisions to the State Operations Manual Chapter 10 – IDR and Enforcement Procedures for Home Health Agencies and Hospice Programs

To: *NHPCO Provider and State Members*
From: *NHPCO Regulatory Team*
Date: *May 10, 2024*

Summary at a Glance

On May 4, the Centers for Medicare & Medicaid Services (CMS) posted QSO-24-11-HHA & Hospice, Revisions to the State Operations Manual (SOM) Chapter 10 –Informal Dispute Resolution (IDR) and Enforcement Procedures for Home Health Agencies and Hospice Programs. This memorandum includes guidance to State Agencies (SAs) and CMS Locations[1] on recommending and imposing hospice enforcement remedies, as authorized under Division CC, section 407 of the Consolidated Appropriations Act, 2021.[2] This memorandum also implements hospice informal dispute resolution (IDR) procedures that were finalized in the calendar year (CY) 2024 Home Health Prospective Payment System Rate Update final rule (88 FR 77676).

Key provisions include:

1. **Informal Dispute Resolution Procedures:**
   - The memorandum provides guidance on IDR procedures for hospices. The IDR process permits a hospice that receives a condition-level deficiency (CLD) survey finding(s) to have an informal opportunity to resolve disputes prior to engaging in the formal hearing process.
   - The memorandum outlines the IDR process, which includes submitting a written request within ten calendar days from receipt of the Form, CMS-2567 Statement of Deficiencies and Plan of Correction.
2. **Enforcement Remedies:**
   - The memorandum outlines the enforcement procedures that may be initiated if a hospice is found to be out of compliance with Medicare Conditions of Participation (CoPs). The memorandum also provides guidance on the factors that should be considered in determining whether an enforcement remedy should be imposed.
   - The decision to impose one or more enforcement remedies for a hospice provider would be based on condition-level deficiencies (CLDs) or repeat deficiencies found during the provider survey. Serious deficiencies or repeated non-compliance may result in more severe enforcement actions, such as termination of the Medicare provider agreement or civil money penalties.
   - Potential enforcement actions include the termination of a provider agreement, suspension of payment for all new admissions, temporary management, civil money penalty, directed plan of correction, or directed in-service training.

Changes outlined in the revised SOM Chapter 10 are effective **immediately**.

Please submit comments or questions to regulatory@nhpco.org with "SOM Chapter 10" in the subject line.

[1] CMS Locations were previously called CMS Regional Offices.
[2] This regulatory alert does not address home health agency enforcement and IDR procedures outlined in QSO-24-11.

Informal Dispute Resolution Procedures

Background

In the CY 2024 Home Health final rule, CMS finalized the hospice IDR process to address disputes related to survey CLD findings. The goal of an IDR is to provide a hospice with an informal opportunity to contest one or more CLD findings cited on the statement of deficiencies. In other words, the IDR process is intended to help save time and resources expended by hospices as well as the SA and CMS. This process would be similar to the IDR process already in effect for home health agencies.

A hospice may initiate the IDR process following receipt of the official survey Statement of Deficiencies and Plan of Correction, Form CMS-2567 to address condition-level survey findings. **CMS incorporates the following elements in all cases involving a deficiency cited as a result of a Federal survey:**[3]

1. Notice to the hospice will indicate that the IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing.
2. Notice to the hospice will indicate that counsel may accompany the hospice program. If the hospice chooses to be accompanied by counsel, then it must indicate that in its request for IDR, so that CMS may also have counsel present.
3. CMS will verbally advise the hospice of CMS's decision relative to the informal dispute, with written confirmation to follow.

Hospices may not initiate the IDR process for standard-level findings, which do not trigger an enforcement action and do not have appeal or hearing rights. The IDR would be conducted by the agency who performed the survey. The IDR process may be initiated by hospices under SA monitoring (through a complaint investigation or validation survey) or those under the SFP. However, a hospice may not initiate the IDR process to dispute a hospice's selection into the SFP, or otherwise refute an enforcement action. In addition, initiating the IDR process will not delay the effective date of any enforcement action.

In the CY 2024 Home Health final rule, CMS indicated that hospice programs deemed through a CMS-approved accrediting organization (AO) will submit their IDR request through the hospice's AO. The same IDR process would be observed, and the AO will coordinate with CMS regarding any enforcement actions. Note that a deemed hospice will lose its deemed status when a CLD is cited on a validation or complaint survey. In the case that a CLD is found, CMS returns oversight of the accredited hospice back to the SA until the hospice can demonstrate compliance with CoPs. Once compliance is achieved, CMS will restore the hospice's deemed status and return oversight to the AO.

Process

When a hospice survey indicates a CLD finding or findings, CMS or the SA will provide notice to the hospice in writing of the opportunity to request an IDR of the CLD finding(s). Hospices would receive this notice with the CMS-2567 Statement of Deficiencies and Plan of Correction.

The IDR request must be submitted in writing within the same ten calendar days permitted for submitting an acceptable plan of correction. This request should also address the specific survey findings that are in dispute.

[3] QSO-24-11-HHA & Hospice, pages 8-9.

Mandatory Elements of the IDR Process[4]

1. Agencies may not use the IDR process to delay the formal imposition of sanctions or to challenge any other aspect of the survey process, including:
   - The severity assessment of a deficiency(s) at the standard level that constitutes substandard care or immediate jeopardy (IJ),
   - Sanctions imposed by the enforcing agency,
   - Alleged failure of the survey team to comply with a requirement of the survey process,
   - Alleged inconsistency of the survey team in citing deficiencies among agencies, and
   - Alleged inadequacy or inaccuracy of the IDR process.
2. Hospice programs must be notified of the availability of IDR in the letter transmitting the official Form CMS-2567. The letter should inform the hospice of the following:
   - It may request the opportunity for IDR, and that if it requests the opportunity, the request must be submitted in writing,
   - The written request for IDR from the hospice must include an explanation of the specific CLDs being disputed,
   - The written request must be made within the same ten calendar day period the hospice has for submitting an acceptable plan of correction to the surveying entity,
   - The name and address, e-mail, and phone number of the person to contact at the CMS Location or the SA to request the IDR,
   - The IDR process that is followed in that State, e.g., telephone conference, written communication, or face-to-face meeting, and
   - The name and/or position title of the person who will be conducting the IDR, if known.
3. Failure to complete IDR timely will not delay the effective date of any enforcement action against the hospice.
4. When a hospice is unsuccessful in demonstrating that a deficiency should not have been cited, the SA must notify the hospice in writing that it was unsuccessful.
5. When a hospice is successful in demonstrating that a deficiency should not have been cited or should be revised:[5]
   - The deficiency citation should be marked "deleted" or "revised" as appropriate, and signed and dated by a supervisor of the surveying entity, and
   - Any enforcement action(s) imposed solely because of that deleted or revised deficiency citation should be rescinded.
6. An agency may request IDR for each survey that cites condition-level deficiencies. However, if IDR is requested for deficiencies cited at a subsequent survey, a hospice may not challenge the survey findings of a previous survey for which the hospice either received IDR or had an opportunity for it. Condition-level deficiencies that are not corrected and are carried forward on a subsequent survey are not eligible for the IDR process. New CLDs identified in a subsequent survey are eligible to be reviewed through the IDR process.

While SAs may involve outside qualified persons or entities to participate in the IDR process, the SA is ultimately responsible for IDR decisions. However, CMS may reject the IDR determination and make its own binding determination of non-compliance for dually participating or Medicare-only hospices.

[4] QSO-24-11-HHA & Hospice, pages 9-11.

[5] The hospice may request a new, clean copy of the Form CMS-2567. However, this form will be the releasable copy only when the hospice signs and provides a new plan of correction.

Impact

The IDR process will <u>not</u> postpone or delay the effective date of any enforcement action. Moreover, a hospice's failure to complete an IDR will not delay the effective date of any enforcement action.

If the SA revises or removes survey findings based on IDR results, the CMS-2567 would be revised to reflect the results, provided that CMS accepts the findings. This would also include an adjustment to any enforcement remedies imposed specifically in response to overturned deficiency findings.

Enforcement Remedies

Congress provided the Secretary of the U.S. Department of Health and Human Services (HHS) with the authority to impose enforcement remedies for hospices through the Consolidated Appropriations Act, 2021, which incorporated provisions from the Helping Our Senior Population in Comfort Environments (HOSPICE) Act. Enforcement remedies provide CMS with additional enforcement options to encourage poor-performing hospices to come into substantial compliance with hospice Medicare CoP requirements. In the CY 2022 Home Health Prospective Payment System final rule (86 FR 62240), CMS implemented statutory provisions to set forth enforcement remedies that may be imposed instead of, or in addition to, termination of a hospice's Medicare provider agreement.[6] These enforcement remedies include:

- civil money penalties,
- directed in-service training,
- directed plans of correction,
- suspension of payment for new admissions, and
- temporary management of a hospice found to have condition-level deficiencies.

CMS is not required to impose an enforcement remedy instead of terminating a provider agreement to ensure patient safety. If CMS or the SA determines that a hospice CLD immediately jeopardizes the health or safety of the hospice's patients, then CMS will inform the provider of the IJ situation and the hospice must take action to correct the deficiencies. If the IJ is not removed, CMS will terminate the hospice's provider agreement,[7] as well as impose additional enforcement remedies before the effective termination date.

As noted above, a deemed hospice will lose its deemed status when a CLD is cited. In the case that a CLD is found, CMS returns oversight of the accredited hospice back to the SA until the hospice can demonstrate compliance with CoPs. ***During the time that a SA has oversight over the hospice, the SA, not the AO, will follow procedures for the imposition of any enforcement remedies.*** Once compliance is achieved, CMS will restore the hospice's deemed status and return oversight to the AO.

CMS indicates that "[r]egardless of whether the condition level non-compliance is identified at the branch (HHA), multiple location (hospice), or the parent location, all sanctions/remedies imposed would apply to the parent HHA or hospice and its respective branches or multiple locations."[8]

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[6] CMS has published training modules, titled, Enforcement Process for Home Health Agency and Hospice Programs, for CMS Locations on the imposition of hospice program enforcement remedies on the CMS Quality, Safety, and Education Portal (QSEP) website: https://qsep.cms.gov/pubs/CourseMenu.aspx?cid=0CMSENFPRCS_HHAHOSPC.

[7] When a provider agreement is terminated, a hospice must appropriately and safely transfer its patients to another local hospice within 30 days of termination. This includes providing the receiving hospice with information, assistance, and any arrangements necessary to facilitate a safe and orderly transfer. Medicare payment to a terminated hospice for its current patient services will continue up to 30 days after termination. See 42 CFR §489.55.

[8] QSO-24-11-HHA & Hospice, page 13.

Effective Date

Once an enforcement remedy is imposed for a hospice, it is effective as of the date in the notice letter for the enforcement remedy being imposed. All enforcement remedies "remain in effect and continue until the [hospice] has demonstrated and is determined to be in substantial compliance with all CoPs."[9]

Enforcement Actions Involving an IJ Citation

When there is an IJ to patient health or safety finding, CMS will complete **termination procedures** within **23 days** from the **last day of the survey** that found the IJ, if not removed. Termination procedures will not be stopped unless the IJ removal is verified through onsite verification.

In addition to termination, CMS may impose one or more enforcement remedies for hospices, although the agency makes clear that enforcement actions for IJ deficiencies should be swift. Note that the imposition of an enforcement remedy in addition to termination does not extend the timeframe to remove a hospice IJ.

Enforcement Actions <u>Not</u> Involving an IJ Citation

CMS will either terminate a hospice agreement following the 90-day termination track or impose one or more enforcement remedies for a hospice that is no longer in compliance with the CoPs, because:

- the deficiency or deficiencies do not constitute IJ but substantially limit a hospice's capacity to provide adequate care, or
- the hospice has repeat noncompliance that results in a CLD based on its failure to correct and sustain compliance.

In cases where an enforcement remedy is imposed, CMS will **terminate** the hospice provider agreement within six **months** of the **last day of the survey** if the hospice is not in substantial compliance with the CoPs and has not corrected the CLD(s).

Factors Considered in the Selection of Enforcement Remedies

When selecting an enforcement remedy, QSO-24-11 instructs the CMS Location to "consider the extent to which the noncompliance is the result of a one-time mistake, larger systemic concerns, or an action of disregard for patient health and safety."[10] **The following factors are considered in selecting an enforcement remedy:**

- The extent to which the deficiencies pose IJ to patient health and safety.
- The nature, incidence, manner, degree, and duration of the deficiencies or noncompliance.
- The presence of repeat deficiencies, the hospice program's overall compliance history and any history of repeat deficiencies at either the parent or branch or multiple locations.
- The extent to which the deficiencies are directly related to a failure to provide quality patient care.
- The extent to which the hospice program is part of a larger organization with performance problems.
- An indication of any system-wide failure to provide quality care.

CMS may also review other factors, such as the history of the hospice's compliance with CoPs, particularly the cited deficiency(ies). See Table 1 for a high-level overview of enforcement remedies and factors considered for their selection.

[9] QSO-24-11-HHA & Hospice, pages 15 – 16.
[10] QSO-24-11-HHA & Hospice, page 15.

Table 1. Available Enforcement Remedies and Factors for Selection[11]

Available Enforcement Remedy	Factors to Consider for Selection
All Enforcement Remedies	• The extent to which the deficiencies pose IJ to patient health and safety. • The nature, incidence, manner, degree, and duration of the deficiencies or noncompliance. • The presence of repeat deficiencies, the hospice program's overall compliance history and any history of repeat deficiencies at either the parent hospice program or any of its multiple locations. • The extent to which the deficiencies are directly related to a failure to provide quality patient care. • The extent to which the hospice program is part of a larger organization with performance problems. • An indication of any system-wide failure to provide quality care.
Civil Money Penalty (CMP)	When repeat deficiencies exist. • Upper range of CMPs for IJ situations. • Middle range of CMPs for noncompliance that is directly related to poor quality patient care outcomes (non-IJ). • Lower range of CMPs for noncompliance that is related predominately to structure or process-oriented conditions.
Suspension of Payment for All New Admissions (SPNA)	When condition-level deficiencies relate to poor patient care outcomes.
Temporary Management	When failure to comply with the CoPs is directly related to management limitations, or When current management oversight is likely to impair the hospice's ability to return to full compliance, or When needed, based on the above situations, to oversee orderly involuntary termination/closure and safe transfer of patients to another local hospice.
Directed Plan of Correction (DPOC)	When the hospice program has deficiencies that warrant direction for the provider to take specific actions, or When the hospice program fails to develop an acceptable plan of correction for condition-level deficiencies.
Directed In-Service Training	When education is likely to correct the deficiencies and help the hospice program achieve substantial compliance.

To determine the amount of a CMP, CMS will consider certain factors in addition to those identified above:[12]

- The size of the hospice program and its resources,
- Accurate and credible resources, such as PECOS, Medicare cost reports and Medicare/Medicaid claims information that provide information on the operation and resources of the [hospice], and
- Evidence that the hospice program has a built-in, self-regulating quality assessment and performance improvement system to provide proper care, prevent poor outcomes, control patient injury, enhance quality, promote safety, and avoid risks to patients on a sustainable basis that indicates the ability to meet the conditions of participation and to ensure patient health and safety.

[11] QSO-24-11-HHA & Hospice, pages 16 – 17.
[12] QSO-24-11-HHA & Hospice, page 20

Civil Money Penalties

CMS may impose a CMP against a hospice based on the following:

- noncompliance with one or more CoPs found through a survey, or
- the presence of repeat deficiencies, i.e., in consideration of the hospice's overall compliance history.

CMS may impose a CMP regardless of whether deficiencies pose immediate jeopardy to patient health and safety. CMPs may be imposed against a hospice for either:

- the number of days that a hospice is not in substantial compliance with one or more CoPs, or
- each instance that a hospice is not in substantial compliance.

Civil Money Penalty Ranges

CMS categorizes CMP amounts into three ranges based on levels of seriousness: upper, middle, and lower:

1. **Upper range penalty** amounts are imposed for a condition-level deficiency that is IJ:[13]
    - If the IJ is cited for actual harm,
    - If the IJ is cited for potential for harm, and
    - If the IJ is cited for a violation of hospice program policies and procedures.
2. **Middle range** amounts are imposed for a repeat and/or condition-level deficiency that does not constitute IJ but is directly related to poor quality patient care outcomes.[14]
3. CMPs in the **lower range** are imposed for a repeat and/or condition-level deficiency that does not constitute IJ and that is related predominately to structure or process-oriented conditions (such as OASIS submission requirements) rather than directly related to patient care outcomes.[15]

Civil Money Penalty Types and Duration

"Per day" CMPs are imposed for the number of days a hospice is not in substantial compliance with the CoPs. These CMPs would begin to accrue on the last day of the survey that found noncompliance and would continue until the hospice achieves substantial compliance with all requirements or has its provider agreement terminated, whichever occurs first. However, for noncompliance that does not pose IJ, accrual may only extend up to a maximum period of six months following the last date of the survey.[16]

A **"Per instance" CMP** is "a single event of noncompliance identified and corrected during a survey, for which the statute authorizes CMS to impose a sanction/remedy."[17] Note that a per instance CMP does mean that only one instance of a CLD noncompliance can be assigned a CMP—there can be more than one instance. Per instance penalties are addressed at §488.1245(b)(6) for hospices, which are adjusted annually for inflation.

A per day and per instance CMP may not be imposed simultaneously for the same CoPs in a hospice survey.

Civil Money Penalty Amounts

42 CFR §488.1245 lays out the ranges and amounts for CMPs. However, these amounts are annually adjusted based on inflation in accordance with 45 CFR part 102. To calculate the CMP penalty, CMS will rely upon updated amounts posted on its website at the Quality, Safety & Oversight Group webpage: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Civil-Monetary-Penalties-Annual-Adjustments.html.

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[13] QSO-24-11-HHA & Hospice, page 22.
[14] QSO-24-11-HHA & Hospice, page 23.
[15] QSO-24-11-HHA & Hospice, pages 23-24.
[16] 42 CFR 488.1245(d)(3)(i).
[17] 42 CFR 488.1205.

Table 2. Hospice Calculation of CMP Adjustments[18]

Hospice Programs				
CFR	**Description**	**Date of Last Penalty Figure or Adjustment**	**2022 Maximum Adjusted Penalty ($)**	**2023 Maximum Adjusted Penalty ($)**
42 CFR 488.1245(b)(2)(iii), (b)(3) – (6), and (d)(1)(ii)	**Maximum daily penalty for each day a hospice program is not in substantial compliance with one or more conditions of participation**	2022	10,000	10,775
42 CFR 488.1245(b)(3)	**Penalty per day for hospice program's noncompliance (Upper Range).**			
	Minimum	2022	8,500	9,158
	Maximum	2022	10,000	10,775
42 CFR 488.1245(b)(3)(i)	Penalty for a hospice program's deficiency or deficiencies that cause immediate jeopardy and result in actual harm.	2022	10,000	10,775
42 CFR 488.1245(b)(3)(ii)	Penalty for a hospice program's deficiency or deficiencies that cause immediate jeopardy and result in potential for harm.	2022	9,000	9,697
42 CFR 488.1245(b)(3)(iii)	Penalty for an isolated incident of noncompliance in violation of established hospice policy.	2022	8,500	9,158
42 CFR 488.1245(b)(4)	**Penalty for a repeat and/or condition level deficiency that does not constitute immediate jeopardy but is directly related to poor quality patient care outcomes (Middle Range).**			
	Minimum	2022	1,500	1,616
	Maximum	2022	8,500	9,158
42 CFR 488.1245(b)(5)	**Penalty for a repeat and/or condition level deficiency that does not constitute immediate jeopardy and that is related predominately to structure or process-oriented conditions (Lower Range).**			
	Minimum	2022	500	539
	Maximum	2022	4,000	4,310
42 CFR 488.1245(b)(6)	**Penalty imposed for instance of noncompliance that may be assessed for one or more singular events of condition-level noncompliance that are identified and where the noncompliance was corrected during the onsite survey.**			
	Minimum	2022	1,000	1,077
	Maximum	2022	10,000	10,775
42 CFR 488.1245(d)(1)(ii)	**Penalty for each day of noncompliance (Maximum).**	2022	10,000	10,775

Civil Money Penalty Adjustments

CMS may change CMP amounts during periods of noncompliance, depending on whether a hospice changed its level of noncompliance during a revisit survey. CMS may **increase** a CMP amount based on the following:

- the hospice program's inability or failure to correct deficiencies,
- the presence of a system-wide failure in the provision of quality care, or
- a determination of IJ with actual harm versus IJ with potential for harm.

CMS may **decrease** a CMP amount to the extent that a hospice demonstrates that "substantial and sustainable improvements have been implemented," even though the hospice has not yet achieved full

[18] https://www.cms.gov/files/document/ltc-hha-clia-hospice-specific-cmp-adjustments-2023.pdf

compliance with the CoPs. There must be evidence of a hospice's earnest efforts to both correct systemic deficiency causes and sustain improvements.

CMP Notices

If CMS or the SA impose a CMP, it will provide the hospice with written notice of the intent to impose an enforcement remedy. This notice includes the following:[19]

- the nature of the noncompliance (regulatory requirements not met),
- the statutory basis for the CMP,
- the amount of the penalty per day of noncompliance or the amount of the penalty per instance of noncompliance during a survey,
- the factors that were considered in determining the amount of the CMP,
- the date on which the per day CMP begins to accrue,
- a statement that the per day CMP will accrue until substantial compliance is achieved or until termination from participation in the program occurs,
- when the CMP payment is due,
- instructions for responding to the notice, including a statement of the hospice program's right to a hearing and information about how to request a hearing, and
- implications of waiving the right to a hearing and information about how to waive the right to a hearing.

For CMPs imposed on a per day basis, CMS will send a final notice containing penalty information to the hospice when it achieves compliance with the CoPs evidenced by an onsite revisit survey. For CMPs imposed on a per instance basis, CMS will similarly send a final notice to the hospice when the provider achieves compliance with the CoPs.

In cases where the provider's agreement has been involuntarily terminated, CMS will send notice after one of the following actions has occurred:[20]

- a final administrative decision is made,
- the hospice program has waived its right to a hearing in accordance with the regulations, or
- the time for requesting a hearing has expired and CMS has not received a hearing request from the hospice program.

Right to a Hearing

Before collecting a CMP, hospices may request a formal hearing with the Administrative Law Judge (ALJ) regarding the noncompliance determination that led to the imposition of the CMP. Once a timely, valid request for a hearing is made,[21] CMS cannot collect the CMP until a final agency determination is reached. However, the request for a hearing would not delay or otherwise end the imposition of the enforcement remedy and would only affect the collection of any final CMP amounts due.

Waiver of Hearing

A hospice may waive its right to a hearing by submitting written notice within 60 days of the date of the notice imposing the CMP. If a hospice timely waives its right to an appeal hearing, CMS will approve the waiver and reduce the CMP amount by 35 percent. The hospice must make payment of the reduced CMP

[19] QSO-24-11-HHA & Hospice, page 29.

[20] QSO-24-11-HHA & Hospice, page 28.

[21] Within 60 days of receipt of the notice of imposition of a penalty, the hospice may file a request directly to the Departmental Appeals Board in the Office of the Secretary, Department of Health and Human Services with a copy to the State and CMS.

amount within 15 days of receipt of the waiver approval and CMP reduction notice. If a hospice does not timely waive its right to a hearing, it will not receive a CMP reduction.

Civil Money Penalty Settlement

The CMS Location may settle CMP cases at any time prior to a final administrative determination. If a settlement decision is reached, the settlement should not be for a better term than had the hospice opted for a 35 percent reduction.

When Civil Money Penalty Payment is Due

Payments are due for all CMPs within 15 days from any of the following:

- after a final administrative decision when the hospice program achieves substantial compliance before the final decision or the effective date of termination before final decision,
    - A final administrative decision includes an ALJ decision and review by the Departmental Appeals Board, if the hospice program requests a review of the ALJ decision.
- after the time to appeal has expired and the hospice program does not appeal or fails to timely appeal the initial determination,
- after CMS receives a written request from the hospice program requesting to waive its right to appeal the determinations that led to the imposition of a CMP,
- after substantial compliance is achieved, or
- after the effective date of termination.

Suspension of Payment

CMS may suspend payment for new Medicare admissions anytime a hospice is found to be out of substantial compliance, as long as long as:

- the hospice is provided written notice at least two calendar days before the effective date in IJ situations, and
- at least 15 calendar days before the effective date in non-IJ situations.

This suspension would not apply to patients who have been receiving care from the hospice before the suspension effective date. CMS will end the suspension when the provider agreement is terminated or when CMS finds the hospice to be in substantial compliance with all CoPs.

Temporary Management

42 CFR 488.1235(a) provides that "CMS may impose temporary management of a hospice program if it determines that a hospice program has a condition-level deficiency and CMS determines that management limitations or the deficiencies are likely to impair the hospice program's ability to correct the noncompliance and return the hospice program to compliance with all of the conditions of participation within the timeframe required." Notice to appoint a temporary manager must be provided to the hospice at least 15 calendar days before the temporary management effective date. However, when there is an IJ, this notice must only be provided at least two calendar days in advance of the effective date.

Temporary management will continue until one of the following occurs:[22]

- CMS determines that the hospice program has achieved substantial compliance and has the management capability to ensure continued compliance with all the conditions of participation.
- CMS terminates the provider agreement.
- The hospice program resumes management control without CMS approval. In this case, CMS initiates termination of the provider agreement and may impose additional remedies.

[22] 42 CFR 488.1235(c).

- Temporary management will not exceed a period of six months from the date of the survey identifying noncompliance.

Directed Plan of Correction

CMS may impose a directed plan of correction (DPOC) when a hospice has one or more CLDs that warrant directing the hospice program to take specific action, or the hospice fails to submit an acceptable plan of correction.[23]

Notice to impose a DPOC must be provided to the hospice at least 15 calendar days before the DPOC effective date. However, when there is an IJ, this notice must only be provided at least two calendar days in advance of the effective date.

Elements of a DPOC include:[24]

- how the hospice program will correct each deficiency,
- how the hospice program will act to protect patients in similar situations,
- how the hospice program will ensure that each deficiency does not recur,
- how the hospice program will monitor performance to sustain solutions, and
- the timeframe in which corrective actions will be taken.

Directed In-Service Training

Directed in-service training may be used for a hospice when the State, CMS, or the temporary manager believes that education is likely to correct the deficiencies and will help the hospice achieve substantial compliance. Hospice staff must attend directed in-service training. Note that the hospice must bear the expense of any directed in-service training for its staff.

After training has been completed, the SA will determine whether substantial compliance has been achieved by the hospice. If substantial compliance is not achieved, CMS may impose on or more additional enforcement remedies.

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[23] 42 CFR 488.1250(a).

[24] QSO-24-11-HHA & Hospice, page 39.