Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CMS'S RELIANCE ON ILLINOIS LICENSURE REQUIREMENTS COULD NOT ENSURE THE QUALITY OF CARE PROVIDED TO MEDICAID HOSPICE BENEFICIARIES

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

June 2014
A-05-12-00028

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

CMS's reliance on Illinois licensure requirements could not ensure the quality of care provided to Medicaid hospice beneficiaries.

WHY WE DID THIS REVIEW

Hospice care is a program of palliative care that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family. Hospices must comply with Federal and State requirements to ensure that hospice care is furnished by qualified workers. Prior Office of Inspector General (OIG) reviews of personal care services (PCS) found that services were provided by PCS attendants who did not meet State qualification requirements. OIG is performing reviews in various States to determine whether similar vulnerabilities exist at hospices.

The objective of this review was to determine whether the Centers for Medicare & Medicaid Services' (CMS) reliance on Illinois licensure requirements for hospice workers ensured quality of care and that adequate protection was provided to Medicaid hospice beneficiaries.

BACKGROUND

A hospice is a public agency, private organization, or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. Hospice care can be provided to individuals in a home, hospital, nursing home, or hospice facility.

In Illinois, the Department of Healthcare and Family Services (State agency) administers the Medicaid program in accordance with a CMS-approved State plan. The State plan establishes what services the Medicaid program will cover, including hospice care when it is provided by a licensed hospice.

A Medicaid participating hospice must meet the Medicare conditions of participation for hospices, one of which requires a hospice to be licensed if State or local law provides for licensing of hospices. Hospice providers that fail to meet conditions of participation may be required to enter into a plan of correction or be subject to termination from the Medicare and Medicaid programs. However, a hospice provider may not be subject to disallowance of past claims if found to be noncompliant or deficient with standards in the conditions of participation. CMS relies on the States to license hospices within their jurisdictions. In Illinois, the Department of Public Health approves and issues hospice licenses. To be licensed, hospices must comply with certain hospice worker requirements.

Qualified individuals must provide hospice care services in accordance with Federal and State regulations. Hospice care services include, but are not limited to, nursing care, home health aide services, physical therapy, social worker services, and spiritual care. When hospice care is furnished to an individual residing in a nursing facility, hospice care payments include payments for room and board in addition to hospice care services.

When a beneficiary is eligible for both Medicare and Medicaid (dually eligible) and elects the hospice benefit, Medicare pays for the hospice care services, and Medicaid pays for the room and board portion only. Hospice workers provide direct care to dually eligible beneficiaries and affect the quality of care provided to these beneficiaries.

HOW WE CONDUCTED THIS REVIEW

We limited our review to Medicaid hospice claims of $100 or more paid to Illinois hospices during the 2-year period January 1, 2009, through December 31, 2010. From a total of 56,044 hospice claims, we reviewed a random sample of 120 claims. A claim represented the Medicaid costs for room and board, or hospice care services, or both, paid for one beneficiary during a month. We reviewed 102 claims for room and board, 12 claims for hospice care services, and 6 claims for both room and board and hospice care services. For these 120 claims, we reviewed the qualifications of the 613 corresponding hospice workers, from 42 hospices, who provided direct care to the Medicaid beneficiaries during the month.

WHAT WE FOUND

CMS's reliance on Illinois licensure requirements could not ensure quality of care and that adequate protection was provided to Medicaid hospice beneficiaries. We determined in most cases that hospices did not meet State hospice licensure requirements related to hospice workers. Of the 120 claims that we sampled, 110 involved direct care provided by unqualified hospice workers. On the basis of these sample results, we estimated that 51,374 of the 56,044 claims covered by our review were associated with unqualified hospice workers.

Of the 110 claims that involved direct care provided by unqualified hospice workers, 93 claims were for room and board only, with Medicare covering the corresponding hospice care service claims. The remaining 17 claims included hospice care services covered by Medicaid. Unqualified hospice workers affect only Medicaid payments for hospice care services, not payments for room and board; therefore, on the basis of our sample results, we estimated that $13,390,913 ($8,163,671 Federal share) in Medicaid payments for hospice care services included in the claims covered by our review were provided by unqualified hospice workers.

For the 110 claims that involved direct care provided by unqualified hospice workers (38 of which had more than 1 type of deficiency), the following licensure requirements were not met:

- initial health evaluation requirements (110 claims),
- background check requirement (20 claims),
- training requirements (17 claims),
- personnel file requirements (12 claims),
- written job description requirement (5 claims), and

- hospice worker certification requirement (2 claims).

WHAT WE RECOMMEND

To improve protection provided to Medicaid hospice beneficiaries, we recommend that CMS:

- work with the State agency and the Illinois Department of Public Health to ensure that hospices meet the State licensure requirements for hospice workers and

- consider working with the State agency to modify the State agency's hospice payment conditions by implementing provisions similar to the State licensure requirements for hospice workers.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency had no further comments or additional information to present.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Hospice care is a program of palliative care that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family. Hospices must comply with Federal and State requirements to ensure that hospice care is furnished by qualified workers. Prior Office of Inspector General (OIG) reviews of personal care services (PCS) found that services were provided by PCS attendants who did not meet State qualifications requirements.[1] OIG is performing reviews in various States to determine whether similar vulnerabilities exist at hospices.

OBJECTIVE

Our objective was to determine whether the Centers for Medicare & Medicaid Services' (CMS) reliance on Illinois licensure requirements for hospice workers ensured quality of care and that adequate protection was provided to Medicaid hospice beneficiaries.

BACKGROUND

The Medicaid Program: How It Is Administered

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the Medicaid program. In Illinois, the Department of Healthcare and Family Services (State agency) administers the Medicaid program in accordance with a CMS-approved State plan. The State plan establishes what services the Medicaid program will cover, including hospice care when it is provided by a licensed hospice.

A Medicaid participating hospice must meet the Medicare conditions of participation for hospices and have a valid provider agreement to provide hospice care (*State Medicaid Manual* § 4305). One of the conditions of participation requires a hospice to be licensed if State or local law provides for licensing of hospices (42 CFR § 418.116). Hospice providers who fail to meet conditions of participation in 42 CFR part 418 may be required to enter into a plan of correction or be subject to termination from the Medicare and Medicaid programs. However, a hospice provider may not be subject to disallowance of past claims if found to be noncompliant or deficient with standards in the conditions of participation. CMS relies on the States to license hospices within their jurisdictions. In Illinois, the Department of Public Health approves and issues hospice licenses. To be licensed, hospices must comply with certain hospice worker requirements.

When hospice care is furnished to an individual residing in a nursing facility, hospice care payments include payments for room and board in addition to hospice care services. If a beneficiary is eligible for both Medicare and Medicaid (dually eligible) and elects the hospice

[1] U.S. Department of Health and Human Services, OIG, portfolio entitled *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement*, issued November 15, 2012.

benefit, Medicare pays for the hospice care services, and Medicaid pays for the room and board portion only. Hospice workers provide direct care to dually eligible beneficiaries and affect the quality of care provided to these beneficiaries.

Hospices Provide Care to Terminally Ill Patients

A hospice is a public agency, private organization, or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. Hospice care can be provided to individuals in a home, hospital, nursing home, or hospice facility.

Qualified individuals must provide hospice care services in accordance with Federal and State regulations. Hospice care services include, but are not limited to, nursing care, home health aide services, physical therapy, social worker services, and spiritual care.

HOW WE CONDUCTED THIS REVIEW

We limited our review to Medicaid hospice claims[2] of $100 or more paid to Illinois hospices during the 2-year period January 1, 2009, through December 31, 2010. From a total of 56,044 hospice claims, we reviewed a random sample of 120 claims. A claim represented the Medicaid costs for room and board, or hospice care services, or both, paid for one beneficiary during a month.[3] For these 120 claims, we reviewed the qualifications of the corresponding 613 hospice workers, from 42 hospices, who provided direct care to the Medicaid beneficiaries during the month.

We conducted this performance audit 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.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our sample design and methodology, and Appendix C contains our sample results and estimates. Appendix D contains excerpts from the applicable State regulations.

FINDINGS

CMS's reliance on Illinois licensure requirements could not ensure quality of care and that adequate protection was provided to Medicaid hospice beneficiaries. We determined that in most cases hospices did not meet State hospice licensure requirements related to hospice

[2] For this report, we define a claim as a group of paid claim lines for hospice care provided by one hospice to a single beneficiary during a single month.

[3] We reviewed 108 claims for room and board and 18 claims for hospice care services. The total exceeds 120 because 6 claims were for both room and board and hospice care services.

workers. Of the 120 claims that we sampled, 110 involved direct care provided by unqualified hospice workers. On the basis of these sample results, we estimated that 51,374 of the 56,044 claims covered by our review were associated with unqualified hospice workers. Of the 110 claims involving direct care provided by unqualified hospice workers, 17 claims included hospice care services. We estimated that $13,390,913 ($8,163,671 Federal share) in Medicaid payments for claims covered by our review were for hospice care services provided by unqualified workers.

LICENSURE REQUIREMENTS FOR HOSPICE WORKERS WERE FREQUENTLY NOT MET

Of the 120 claims that we sampled, 110 involved direct care provided by workers at hospices that did not meet 1 or more of the State's licensure requirements for hospices. For this report, we refer to these hospice workers as unqualified. The table below summarizes, by licensure requirement, the number of sampled claims associated with the deficiencies that we identified.

Summary of Sampled Claims Associated With Unqualified Hospice Workers

Type of Deficiency	Claims Affected[4]
Initial health evaluation requirements were not met	110
Background check requirement was not met	20
Training requirements were not met	17
Personnel file requirements were not met	12
Written job description requirement was not met	5
Hospice worker certification requirement was not met	2

On the basis of these sample results, we estimated that 51,374 of the 56,044 claims covered by our review were associated with unqualified hospice workers.

Of the 110 sampled claims that involved direct care provided by unqualified hospice workers, 93 claims were for room and board only, with Medicare covering the corresponding hospice care service claims. The remaining 17 claims included hospice care services covered by Medicaid. Unqualified hospice workers affect only Medicaid payments for hospice care services, not payments for room and board; therefore, on the basis of our sample results, we estimated that $13,390,913 ($8,163,671 Federal share) in Medicaid payments for hospice care services included in the claims covered by our review were provided by unqualified hospice workers.

Hospices Did Not Meet Initial Health Evaluation Requirements for Workers

For hospice workers associated with 110 of the 120 sampled claims, hospices did not ensure that an initial health evaluation was completed for each worker in compliance with State licensure requirements. State regulations specify that an initial health evaluation be completed within 30 days of hire and include a health inventory, physical examination, and tuberculin skin test.[5]

[4] The total exceeds 120 because 38 claims had more than 1 type of deficiency.

[5] 77 Ill. Admin. Code § 280.2045, see Appendix D.

Hospices Did Not Meet the Background Check Requirement for Workers

For 20 sampled claims, hospices did not ensure that a background check was completed in compliance with the State licensure requirements. State regulations specify that a background check must be completed for all nonlicensed workers employed by or volunteering for the hospice, which includes, but is not limited to, certified nursing assistants and clergy.[6]

Hospices Did Not Meet Training Requirements for Workers

For 17 sampled claims, hospices did not meet training requirements as required by State licensure requirements. Specifically:

- For six claims, hospices did not document inservice training. State regulations specify that all workers must attend inservice training programs pertaining to their assigned duties at least annually. Written records of program content and personnel attending each session must be maintained.[7]

- For one claim, a hospice did not document that a hospice worker completed an orientation program. State regulations specify that all new workers must complete an orientation program covering, at a minimum, the program's philosophy and goals; job orientation, emphasizing allowable duties of the new worker; safety; and appropriate interactions with patients and families.[8]

- For 10 claims, hospices did not document both inservice training and orientation.

Hospices Did Not Meet Personnel File Requirements for Workers

For 12 sampled claims, hospices did not maintain all required information for hospice workers. State licensure requirements specify that employment application forms must be completed on each worker and kept on file in the program's central office. The file must contain, at a minimum, home address; telephone number; Social Security number; educational background; documentation of current professional certification, licensure, or registration, as applicable; and past employment history, including dates, positions held, and reasons for leaving. The date of employment and position held must be documented in each file. [9]

[6] 77 Ill. Admin. Code § 280.2035; see Appendix D.

[7] 77 Ill. Admin. Code § 280.2040g.

[8] 77 Ill. Admin. Code § 280.2040f.

[9] 77 Ill. Admin. Code § 280.2040b.

Hospices Did Not Meet the Written Job Description Requirement for Workers

For five sampled claims, job descriptions listing the hospice worker's duties were not available.[10] State licensure requirements specify that each worker must have an accurate written job description.[11]

Hospices Did Not Meet the Certification Requirement for Workers

State licensure requirements require that any individual providing home health services be registered in the State.[12]

For one home health aide associated with one claim, the hospice was unable to provide the aide's personnel file or evidence of the aide's certification.

For one aide associated with one claim, the hospice did not ensure that the aide was certified in Illinois at the time the aide provided services. The aide was, however, certified in Iowa and was subsequently certified in Illinois.

CMS'S RELIANCE ON ILLINOIS LICENSURE REQUIREMENTS FOR HOSPICE WORKERS COULD NOT ENSURE THE QUALITY OF CARE PROVIDED TO MEDICAID BENEFICIARIES

CMS relied on State licensure requirements for hospices. However, we found that in most cases hospices did not meet certain State licensure requirements for employee health examinations, background checks, personnel files, job descriptions, and certifications. CMS's reliance on the licensure requirements could not ensure quality of care and that adequate protection was provided to Medicaid beneficiaries. Hospices are licensed in accordance with State regulations and hospices are expected to comply with those regulations.

The effect of the deficiencies that we identified in our review was that hospices could not be sure that hospice workers were free of any health conditions that might have created a hazard for the Medicaid beneficiaries. Further, they could not always demonstrate that the hospice workers met certain State requirements such as meeting background checks, training requirements, and certifications.

RECOMMENDATIONS

To improve protection provided to Medicaid hospice beneficiaries, we recommend that CMS:

[10] Errors were not counted if the hospice had a job description for the employee type, even if the job description was not maintained in the employee file.

[11] 77 Ill. Admin. Code § 280.2040c.

[12] 77 Ill. Admin. Code § 245.70, see Appendix D.

- work with the State agency and the Illinois Department of Public Health to ensure that hospices meet the State licensure requirements for hospice workers and

- consider working with the State agency to modify the State agency's hospice payment conditions by implementing provisions similar to the State licensure requirements for hospice workers.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency had no further comments or additional information to present. The State agency's comments are included in their entirety as Appendix E.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations. CMS's comments are included in their entirety as Appendix F.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For the audit period January 1, 2009, through December 31, 2010, we limited our review to Medicaid payments that the State agency made to hospice providers for hospice care provided to Medicaid beneficiaries as authorized under the State plan. We excluded claims in which the paid amount was less than $100.[13]

After taking into account the exclusions above, we determined that the State processed and paid 56,044 Medicaid claims totaling $142,972,076 ($87,817,445 Federal share) for hospice care services during the audit period. We reviewed a random sample of 120 claims.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we limited our internal control review to the objective of our audit.

We conducted fieldwork from January 2012 through March 2013 at 42 hospices throughout Illinois.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with State agency officials to gain an understanding of the State agency's hospice program;
- obtained Medicaid paid claims for service dates from January 1, 2009, through December 31, 2010, from the State agency;
- identified a sampling frame of 56,044 claims, totaling $142,972,076 ($87,817,445 Federal share);
- selected a random sample of 120 claims from our sampling frame and, for each claim, obtained and reviewed the hospice's documentation to determine whether hospice workers who provided direct care to the beneficiaries in our sample claims were qualified in accordance with Federal and State requirements;
- estimated the amount of Federal Medicaid reimbursement for claims associated with unqualified workers in the total population of 56,044 claims; and

[13] A claim represented the Medicaid costs for room and board, hospice care services, or both, paid for one beneficiary during the month.

- estimated the number of claims that were associated with at least 1 unqualified hospice worker in the total population of 56,044 claims.

We conducted this performance audit 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.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicaid claims[14] of $100 or more that the State made to hospices for care provided from January 1, 2009, through December 31, 2010, for which the State claimed Federal Medicaid reimbursement.

SAMPLING FRAME

The sampling frame was a data file provided by the State agency containing Medicaid payments during the audit period for hospice care. We excluded claims in which the paid amount was less than $100. After these exclusions, the sampling frame was 56,044 Medicaid claims with Medicaid payments of $100 or more paid to hospices during the audit period, for hospice care totaling $142,972,076 ($87,817,445 Federal share).

SAMPLE UNIT

The sample unit was a claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 120 claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the sample units in the frame. After generating the random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the unallowable amounts. Because the State agency had different Federal medical assistance percentages (FMAPs)[15] for the audit

[14] A claim is the group of paid claim lines for hospice care provided by one hospice to a single beneficiary during the month.

[15] The FMAP rate for the claims in our audit period ranged quarterly from 50 percent to 61.88 percent.

period, we calculated the Federal reimbursement amount for each sample claim by applying the applicable FMAP to the total amount determined to be associated with unqualified hospice workers for the sample claim. Errors related to an unqualified hospice worker who provided services associated with more than one claim were counted for each claim in which the unqualified hospice worker provided services. We used the point estimate to determine the dollar amount of Federal Medicaid reimbursement just for claims that included hospice care services provided by unqualified hospice workers and the number of claims associated with unqualified hospice workers.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

HOSPICE CLAIMS ASSOCIATED WITH UNQUALIFIED HOSPICE WORKERS

Sample Results: Total Amounts

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Claims for Hospice Care Services Provided by Unqualified Workers	Value of Claims for Hospice Care Services Provided by Unqualified Workers
56,044	$142,972,076	120	$258,803	17	$28,672

Sample Results: Federal Share Amounts

Frame Size	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Claims for Hospice Care Services Provided by Unqualified Workers	Value of Claims for Hospice Care Services Provided by Unqualified Workers (Federal Share)
56,044	$87,817,445	120	$159,112	17	$17,480

Estimates of Medicaid Payments for Claims Including Hospice Care Services Provided by Unqualified Hospice Workers

(Limits Calculated for a 90-Percent Confidence Interval)

	Total Amounts	Federal Share
Point estimate	$13,390,913	$8,163,671
Lower limit	6,754,952	4,093,795
Upper limit	20,026,874	12,233,547

HOSPICE CLAIMS ASSOCIATED WITH UNQUALIFIED HOSPICE WORKERS

Sample Results

Frame Size	Sample Size	Number of Claims Associated With Unqualified Hospice Workers
56,044	120	110

Estimates of Hospice Claims Associated With Unqualified Hospice Workers
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	51,374
Lower limit	48,356
Upper limit	53,469

APPENDIX D: STATE REGULATIONS FOR HOSPICE WORKERS

STATE REGULATIONS FOR INITIAL HEALTH EVALUATION FOR WORKERS

Pursuant to 77 Ill. Admin. Code § 280.2045:

a) Each employee shall have an initial health evaluation, which shall be used to ensure that employees are not placed in positions that would pose undue risk of infection to themselves, other employees, patients, or family members.

b) The initial health evaluation shall include a health inventory. This inventory shall be obtained from the employee and shall include the employee's immunization status and any available history of conditions that would predispose the employee to acquiring or transmitting infectious diseases in the course of performing anticipated job functions. It shall include any history of exposure to, or treatment for, tuberculosis, any history of hepatitis, dermatologic conditions, chronic draining infections or open wounds.

c) The initial health evaluation shall include a physical examination. The examination shall include at a minimum any procedures needed to:

    1) Detect any unusual susceptibility to infection and any conditions that would increase the likelihood of the transmission of disease, and

    2) Determine that the employee appears to be physically able to perform the job functions that the hospice program intends to assign to the employee.

d) The health inventory and physical examination shall be completed no more than 30 days prior to and no more than 30 days after the date of initial employment.

e) The initial health evaluation shall include a tuberculin skin test, which is conducted in accordance with the requirements of Section 690.720 of the Control of Communicable Diseases Code.

STATE REGULATIONS FOR BACKGROUND CHECKS FOR WORKERS

Pursuant to 77 Ill. Admin. Code § 280.2035:

> A hospice program shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code (77 Ill. Admin. Code Part 955).

Pursuant to 77 Ill. Admin. Code § 955.100:

> This Part applies to all unlicensed individuals employed or retained by a health care employer as home health care aides, nurse aides, personal care assistants, private duty nurse aides, day training personnel, or an individual working in any similar health-related occupation where he or she provides direct care ….

STATE REGULATIONS FOR HOME HEALTH AIDE TRAINING

Pursuant to 77 Ill. Admin. Code § 245.70:

a) Each home health agency and home nursing agency shall ensure that all persons employed as home health aides or under any other title, whose duties are to assist with the personal, nursing or medical care and emotional comfort of the patients, and who are not otherwise licensed, certified or registered in accordance with Illinois law to render such care, comply with one of the following conditions:

    1) Is approved on the Department's Health Care Worker Registry. "Approved" means that the home health aide has met the training or equivalency requirements of this Section and does not have a disqualifying background check without a waiver (see Section 245.72);

    2) Meets training requirements by completion of a training program approved under the Long-Term Care Assistants and Aides Training Programs Code (see 77 Ill. Admin. Code 395); or

    3) Meets equivalencies established in subsection (b) of this Section.

b) Equivalency may be established by any one of the following:

    1) Documentation of current registration from another State.

    2) Documentation of successful completion of a nursing arts course, which included at least 40 hours of supervised clinical experience, in an accredited nurse training program as evidenced by diploma, certificate or other written verification from the school, and successful completion of the written portion of the Department-established nursing assistant competency test.

    3) Documentation of successful completion of a United States military training program that includes the content of the Basic Nursing Assistant Training Program (see 77 Ill. Admin. Code 395), as evidenced by a diploma, certification DD-214, or other written verification, and successful completion of the written portion of the Department-established nursing assistant competency evaluation.

    4) Documentation of completion of a nursing program in a foreign country, including the following, and successful completion of the written portion of the Department-established competency test:

        A) A copy of the license, diploma, registration or other proof of completion of the program;

        B) A copy of the Social Security card; and

C) Visa or proof of citizenship.

c) Requests to establish equivalency shall be submitted to the Department with accompanying documentation ….

APPENDIX E: STATE AGENCY COMMENTS

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
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March 14, 2014

Ms. Sheri L Fulcher
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

Re: Report Number A-05-12-00028

Dear Ms. Fulcher:

We have reviewed the final report, *"CMS's Reliance on Illinois Licensure Requirements Could Not Ensure the Quality of Care Provided to Medicaid Hospice Beneficiaries"*. We appreciate the opportunity to comment.

We have no further comments or additional information to present on the final determination noted in the report. If you have any questions or comments, please contact Amy Lyons, External Audit Liaison, at (217) 558-4347 or through e-mail at amy.lyons@illinois.gov.

Sincerely,

/s/

Theresa Eagleson, Division Administrator, Medical Programs
Illinois Department of Healthcare and Family Services

E-mail: hfs.webmaster@illinois.gov

Internet: http://www.hfs.illinois.gov/

APPENDIX F: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAY - 2 2014

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "CMS's Reliance on Illinois Licensure Requirements Could Not Ensure the Quality of Care Provided to Medicaid Hospice Beneficiaries" (A-05-12-00028)

Thank you for the opportunity to review and comment on the above-referenced OIG Draft Report. OIG's objective was to determine if the Centers for Medicare & Medicaid Services' (CMS) reliance on Illinois licensure requirements for hospice workers ensured quality of care and that adequate protection was provided to Medicaid hospice beneficiaries.

The OIG found that CMS's reliance on Illinois licensure requirements could not ensure quality of care and that adequate protection was provided to Medicaid hospice beneficiaries. Also, OIG determined that in most cases hospices did not meet state hospice licensure requirements related to hospice workers. Of the 120 claims that OIG sampled, 110 involved direct care provided by unqualified hospice workers. On the basis of these sample results, OIG estimated that 51,374 of the 56,044 claims covered by their review were associated with unqualified hospice workers. Of the 110 claims involving direct care provided by unqualified hospice workers, 93 claims were for room and board only, with Medicare covering the corresponding hospice care service claims. The remaining 17 claims included hospice care services covered by Medicaid. Unqualified hospice workers only affect Medicaid payments for hospice care services. OIG estimated that $13,390,913 ($8,163,671 Federal share) in Medicaid payments for claims covered by their review were for hospice care services provided by unqualified workers. For the 110 claims that involved direct care provided by unqualified hospice workers (38 of which had more than one type of deficiency), the following licensure requirements were not met: (1) initial health evaluation requirements (110 claims); (2) background check requirement (20 claims); (3) training requirements (17 claims); (4) personnel file requirements (12 claims); (5) written job description requirement (five claims); and (6) hospice worker certification requirement (two claims).

OIG Recommendation

The OIG recommends that CMS work with the state agency and the Illinois Department of Public Health to ensure that hospices meet the state licensure requirements for hospice workers.

CMS Response

The CMS concurs with OIG's recommendation. CMS does not have the authority to enforce state licensure and/or registration requirements, and CMS also does not have a specific Condition of Participation that addresses state requirements for the licensure and/or registration of non-professional personnel. However, there is a specific regulation at 42 CFR 418.114(d) that the hospice obtain a criminal background check on all personnel providing direct care or having access to patient records in the hospice. While we do not have authority over state licensure/registration requirements, CMS will discuss the report findings with the State Survey Agency and ensure that the Illinois surveyors validate that the requirement for a criminal background check is completed by the agency and that all hospice workers receive initial and ongoing training to perform their duties.

OIG Recommendation

The OIG recommends that CMS consider working with the State Agency to modify the State Agency's hospice payment conditions by implementing provisions similar to the State licensure requirements for hospice workers.

CMS Response

The CMS concurs. While we do not have authority over state licensure/registration requirements, CMS will request information and discuss further with the state agency.

The CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.