MASKING MORTALITY: IS HCA INAPPROPRIATELY SENDING PATIENTS TO HOSPICE?
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# ABOUT SEIU

More than one million healthcare workers across hospitals, in-home care, and in nursing homes are united in the Service Employees International Union (SEIU), the nation's largest union of healthcare workers. SEIU is an organization of nearly 2 million members united by a belief in the dignity and worth of workers and the services they provide. SEIU is dedicated to improving the lives of workers, families, and communities to create a more just and humane society.
EXECUTIVE SUMMARY

HCA Healthcare, Inc. (hereinafter “HCA”) is the largest hospital company in America and is widely regarded as an industry leader, with more than 180 hospitals in some 20 states. What’s more, HCA is astonishingly profitable, with profits of nearly $7 billion in 2021\(^1\) and $5.6 billion in 2022 alone\(^2\).

As has been documented in prior analyses and news reports, HCA’s profits appear to stem at least in part from questionable practices. HCA has been accused of “routinely engag[ing] in practices that maximize profits at the expense of patient care, working conditions, and responsible corporate behavior,”\(^3\) whether it be “understaff[ing] its hospitals as a practice,”\(^4\) or engaging in “questionable inpatient admissions.”\(^5\) Given recent reports documenting concerns that the company is putting profits over patients,\(^6\) we have serious concerns that HCA’s profit-driven practices may carry over into their provision of hospice care.

Hospice care is often considered compassionate care for people in the last phases of terminal conditions, enabling them to live out their last days as fully and comfortably as possible.\(^7\) Yet, our review of lawsuits, Medicare fee-for-service claims data, Statements of Deficiency citations issued by the Centers of Medicare and Medicaid Services (CMS), and other public data suggests that some patients encountering the HCA system of care may be transferred to hospice inappropriately.

Our key findings:

- HCA’s executive compensation structure rewards low in-hospital mortality rates, and transferring patients to hospice can help reduce those mortality rates.
- Analysis of Medicare claims data reveals a recent trend of increasing rates of HCA patients being transferred to hospice.
- In 2021, HCA acquired a controlling interest in a national hospice provider and has stated its intent to expand its hospice footprint.
- HCA has been cited several times for discharging patients to the wrong location – e.g., to the wrong nursing home – or without notice to the post-acute provider, or even without an order from the attending physician, perhaps indicating discharge planning processes are aimed primarily at moving patients out as quickly as possible rather than meeting patient needs.

Considering that the matters discussed in this report literally involve life or death decisions, we believe HCA should investigate these concerns and correct any inappropriate behaviors within their system as soon as possible. Further, we call upon regulators to perform their own investigations and to seek accountability from HCA.
Introductory Case Study

In December 2018, HCA’s TriStar Centennial Medical Center in Nashville, Tennessee was cited by surveyors from the Centers for Medicare & Medicaid Services (CMS) for terminating treatment and putting a patient into hospice. The patient was in a persistent vegetative state, had an Advance Care Plan that provided that she wished to continue living if she was in a “permanent unconscious condition,” and stated that her son was empowered to make care decisions for her. Despite this ACP, treatment was terminated on the basis of the physician’s judgment that continued treatment was not warranted. Her son, who had power of attorney for her healthcare decisions, was informed of this course of action in a phone call.

In this instance, the hospital was cited for not having informed the patient’s representative (her son, who again had power of attorney) concerning her rights governing the discontinuation of care. The investigation also determined that the hospital’s Quality Improvement Officer stated that to her knowledge, the hospital did not give patients or representatives copies of the hospital’s written policies governing advance directives (which is a requirement for hospitals under the Medicare program).

This report will provide evidence that this quick decision to put a patient into hospice may not be an isolated instance across HCA’s hospitals nationwide. We will suggest that in fact such transfers to hospice reflect a broad corporate strategy – and may be driven at least in part by incentives relating to executive bonuses.

Former HCA Surgery Chief Alleges Inappropriate Referrals to Hospice to Boost Profits

In 2018, Dr. Santosh Potdar – who served as the Surgery Chief and Cancer liaison physician at HCA’s Oak Hill Hospital in Brooksville, Florida – filed a federal False Claims Act lawsuit against HCA and his physician group employer, Access Healthcare Physicians. Among the many fraud claims in the suit was an alleged scheme involving Medicare Advantage (the portion of the Medicare program that relies on private insurance companies rather than paying providers directly). Under Medicare Advantage (aka Medicare Part C), the federal government makes monthly payments to insurers that are determined by how many patients the insurer is responsible for and the medical conditions of those patients (so-called “per-member per-month” payments). Dr. Potdar alleges that the Medicare Advantage insurers often have this same payment arrangement with the providers in their provider networks, with “providers standing to gain if their patients are provided fewer services and/or less costly care, because it maximizes the difference between the PMPM payment and the costs incurred.” As a result, Dr. Potdar alleges “Defendants have withheld from their patients necessary medical treatment to optimize their Medicare Part C profits.”

Specifically, Dr. Potdar alleges “For many Access patients, who, because of their health conditions, are no longer profitable to Defendants, Dr. Singh [the CEO of Access Healthcare] and his physicians simply recommend premature referral to hospice. They do so by falsely certifying these patients as
terminals ill [...]” and “given the vulnerability of their target population, Defendants accomplish many transfers to hospice with little patient resistance.”

Dr. Potdar alleges he “has heard similar complaints from his colleagues at [HCA’s] Oak Hill Hospital. As chief of surgery, Relator has learned of numerous instances in which Access hospitalists bypassed attending surgeons to recommend withdrawal of care and transfer to hospice.”

Dr. Potdar alleges that he raised his concerns both to Oak Hill Hospital’s Chief Medical Officer and to the CEO, but he was pressured by his employer to rescind his complaint and was the target of a “concerted effort” to silence and discredit him. This included attempts to revoke his hospital privileges, as well as receiving a letter from Oak Hill’s Board of Trustees instructing him to “cease and desist making any inappropriate negative comments …about Access Healthcare Physicians…or hospital personnel.” The case was voluntarily dismissed by the plaintiff physician in May 2020, following the U.S. Dept. of Justice’s (DOJ) and State of Florida’s notices of non-intervention. However, both the DOJ and the State of Florida “reserve the right to [...] move to intervene in this action, for good cause at a later date.”

**HCA’s Ties to Access Healthcare Physicians, LLC**

Access Healthcare Physicians, the physician group named in Potdar v. HCA Healthcare, Inc., is “a medical group that has thousands of patients through the State of Florida, with 88 medical offices and over 213 health care providers in 25 different cities.”


What’s more, Dr. Pariksith Singh – the CEO of Access Healthcare Physicians and a Defendant in the Potdar lawsuit – was the recipient of HCA’s Frist Humanitarian Award for 2017. The Frist Humanitarian award is named for one of HCA’s founders, Thomas Frist, Sr.; the company describes this award as “one of the highest honors that HCA bestows on employees, physicians and volunteers.”

**HCA’s Troubling Executive Compensation Incentives**

These shocking allegations of certain HCA hospitals inappropriately placing patients into hospice are even more troubling when taking into account the compensation incentives of HCA’s C-suite.

HCA’s senior officers – including CEO Sam Hazen, CFO William Rutherford, Group Presidents Jon Foster and Charles Hall, and Chief Legal Officer Michael McAlevey – are compensated
partly through a “Performance Excellence Program” (or “PEP”). (Note that Charles Hall retired at the end of 2022. 28) Eighty percent of the incentive awards under PEP are based upon the company’s financial performance, while twenty percent is based upon “Quality/Patient Care.” 29 The metrics upon which these patient care and quality PEP incentive awards are based fall into three categories: performance on Healthcare-Associated Infections, Morbidity and Mortality, and Patient Care Experience. 30 A metric called the “Mortality Index” 31 – which is partially calculated based upon in-hospital deaths and to which PEP payouts began being tied in 2021 32 – is of particular note and warrants closer examination.

**Mortality Index Background**

This “Mortality Index” is based on the IBM Watson Health Risk-Adjusted Mortality model. 33 Per IBM, “Patient survival is a universally accepted measure of hospital quality. The lower the mortality index, the greater the survival of the patients in the hospital […] While all hospitals have patient deaths, this measure can show where deaths did not occur but were expected […].” 34

According to IBM, the index is calculated “based on the number of actual in-hospital deaths in the two most current years of data, divided by the number expected, given the risk of death for each patient […]. Palliative care patients (Z515) are included in the risk model. POA [Present on Admission] coding is used in the risk model to identify pre-existing conditions for accurate assessment of patient severity.” 35

However, IBM’s methodology also states that “Do not resuscitate (DNR) patients (Z66)” and “Post-discharge deaths” are excluded from the calculation. 36 We cannot speak with certainty how “palliative care patients” are included in IBM’s risk model, but hospice transfers would seem to be included in the “post-discharge deaths” that are excluded from calculation, because such patients are discharged formally from the hospital and admitted into hospice care; each provider would submit separate claims for billing. The exclusions of these elements from the mortality index calculation could create incentives for increased rates of DNR orders, as well as increased rates of discharges to settings where patient deaths will not be counted against HCA executives’ compensation targets.

**HCA Performance on the “Mortality Index”**

HCA’s performance on this “Mortality Index” has been stellar in recent years, far exceeding targets, thereby boosting HCA’s overall quality-related executive compensation payouts. In 2022, for example, HCA’s mortality index performance aided HCA executives in meeting their quality-related payouts, despite missing targets on both patient care experience metrics (the care experience metrics combined represent 40% of quality payouts). 37 A similar trend was also observed in 2021, where HCA again missed patient care experience metrics but greatly exceeded the ones related to mortality. 38

HCA’s executive payout incentives, coupled with the troubling allegations in the Potdar v. HCA Healthcare, Inc. lawsuit, raise serious questions about HCA’s practices around hospice care utilization. Since HCA’s C-suite executives receive bonuses based upon preventing deaths among inpatients of HCA hospitals, we have serious concerns that HCA’s compensation policy may
have created an incentive to artificially suppress its mortality rates by discharging patients out of its hospitals into hospice care before their deaths.

Analysis of Medicare Data Suggests Concerns among HCA's Hospice Transfer Rates

In order to enroll in Medicare's hospice program, patients must have a terminal illness and a prognosis of less than 6 months to live. Once they choose to enroll in hospice services, they agree to stop conventional treatment of their terminal illness and receive only comfort care.\(^{39}\)

Within the context of Dr. Potdar’s allegations and apparent corporate incentives to reduce in-hospital mortality, we find some recent hospice-related utilization patterns at HCA troubling. Our analysis of Medicare claims data shows that the rate of HCA hospital inpatients that enter hospice services immediately upon discharge has risen markedly in recent years.\(^{40}\) Figure 1 shows that the average hospice transfer rate among HCA hospital discharges was nearly 40% above the national average in 2021 and jumped from about 3.4% in 2017 to about 5.2% in 2021, which is a growth rate of more than 50% in just four years.

**Figure 1. Hospital Transfer Rates to Hospice Medicare Fee-for-Service Claims**
Figure 1 shows that HCA’s system average hospice transfer rate has been above the national average throughout this entire period, though clearly it pulled even further away from it during the final two years of this analysis. Moreover, our analysis shows that this deviance from national trends seems to be present throughout much of the HCA system; more than 70 of HCA’s 140 hospitals in our analysis ranked above the 80th national percentile for their hospice transfer rates in 2021.

Compare these trends to those of in-hospital mortality rates, which are seen in Figure 2. Just as we saw in our analysis of hospice transfer rates, both the national average and the HCA system average in-hospital mortality rates have increased over this period. But unlike what we saw with hospice transfer rates, HCA’s growth rate on this metric is very slight, and it does not fit the overall national trend of strong growth during this period. In fact, HCA’s average in-hospital mortality rate is below the national average in every year during this period.

Figure 2. In-Hospital Mortality Rates

Medicare Fee-for-Service Claims

It is not lost on us that the final two years of this period were years within the COVID pandemic, and that the deadliness of that disease understandably would increase in-hospital mortality rates nationally, and that it would likely increase the potential need for hospice services for patients following hospital stays as well. However, the seemingly contradictory trend between HCA and their national peers on these rates raises questions, particularly considering the allegations and corporate incentives described earlier within this report.
With those incentives in mind, we are particularly concerned with the rate at which HCA's hospital patients appear to die extremely soon after their transfer to hospice. Figure 3 explores the rate at which patients who are transferred to hospice die on the same day of their hospice transfer, and it compares HCA's system average to the national average among hospitals. The findings are striking; HCA's rate more than doubles between 2017 and 2021, jumping from about 7% to about 18% during this time.

**Figure 3. Percent of Hospital Transfers to Hospice Where Patients Died on the Day of Hospice Transfer**

*Medicare Fee-for-Service Claims*

Put another way, nearly one in five Medicare fee-for-service patients who entered hospice in 2021 immediately upon discharge from an HCA hospital died on the very same day that they were discharged into hospice. That is a strong outlier from national trends; in 2021, HCA’s system average rate of roughly 18% is more than double the national average.

In short, our findings from this data analysis lead us to worry that the potentially perverse financial incentives to transfer hospital inpatients to hospice may be affecting the related care decisions at HCA hospitals. These data trends are especially concerning since HCA has been rapidly expanding in the hospice/home health space in recent years.
HCA Hospice & Corporate Strategy

HCA’s Hospice Expansion & Presence

HCA has been expanding its footprint within the hospice and home health space in the last couple of years. In July 2021, for example, HCA acquired an 80% stake in Brookdale Health’s home health, hospice and outpatient therapy business for $400 million. This acquisition added 57 home health locations, 22 hospice locations and 84 outpatient centers across 26 states to the HCA portfolio. Two months later, HCA sold some of those assets that were located in markets not already served by HCA’s other providers; this sale included 11 hospice locations.

Regarding the Brookdale acquisition, HCA CFO Bill Rutherford stated, “And with that Brookdale, we also acquired hospice services. And as we see more and more expansion and the need for the hospice and palliative care, that is a natural growth engine to us.” Rutherford continued, suggesting that home health and hospice care were “the next generation of growth opportunities” for HCA.

Here is a sampling of the hospice services offered by HCA in some of their key markets:

- California (Riverside Community Hospice & Family Care)
- Colorado (HealthONE Hospice & Family Care)
- Kansas/Missouri (HCA Midwest Hospice & Family Care)
- Texas
  - Austin (St. David’s Hospice & Family Care)
  - Dallas/Fort Worth (Medical City Hospice & Family Care)
  - Houston (HCA Houston Hospice & Family Care)
  - San Antonio (Methodist Hospice & Family Care)
- North Carolina (CarePartners)

HCA’s Hospice Strategy

As noted above, HCA’s CFO Bill Rutherford has indicated that home health and hospice care were “the next generation of growth opportunities” for HCA. What does that look like in practice? Rutherford and CEO Sam Hazen’s disclosures to investors provide some interesting insights.

Firstly, these post-acute services are viewed as “discharge planning tools” that also help keep patients within the HCA system:

- “We think home health makes all the sense in the world from a strategic standpoint, not only offering that service to patients that were in the network. It becomes kind of a discharge planning tool for our hospitals where we have an agency that we can utilize the discharge patients to the extent they need home health services post an inpatient stay. And it allows us just to maintain and capture those patients within the network on there.”
  - CFO Bill Rutherford at Oppenheimer’s 32nd Healthcare Conference, 3/15/22
- “On post-acute, let me speak to that. Obviously, home care opportunity and hospice opportunity to us, we believe, is a significant expansion of the services we offer. And the opportunities for integrating those patients who are discharged and we discharge about
250,000 patients a year into home care creates an opportunity for us to coordinate care better, stay connected to the patient after they leave our facilities and ultimately integrate them more effectively in the HCA health care system. So we see a nice broad opportunity. We believe home care provides multiple channels of value for us some of which are in the discharges that we talked about, some of it’s in better case management and discharge planning and some of it is staying connected to the patient when they repurchase health care.”  

Secondly, these post-acute services are viewed by HCA as a means to facilitate better “throughput” and to create “efficiencies” within its hospitals:

- “[...] The second thing that it does is that it creates efficiency inside of our hospitals, potentially, for better discharge planning and better sort of throughput. And the third thing it does is it keeps us connected to the patient when they’re at home. And so if they need to repurchase health care, then we’re sort of connected there. So there’s multiple channels of value potentially with that.”

- “… We’ve advanced our capabilities in post-acute with our own acquisitions and development as well as relationships with others. And I think the combination of all of those elements create an opportunity for us to gain more efficiencies through our case management programs overall.”

Greater “efficiencies” or not, staff have expressed concerns about the quality of hospice care provided by HCA entities. A former nurse from CarePartners, a hospice provider under the umbrella of HCA’s Mission Hospital in Asheville, NC, has expressed that hospice care “has deteriorated under HCA.” HCA acquired the non-profit system Mission Health in 2019. In the nurse’s “exit statement” to management, she mentions that problems primarily resulted from staffing cuts and the “introduction of three new electronic records systems” related to patient medication. She stated: “Both have essentially created a vicious cycle of downward spiraling care, demoralized staff, and patient and family dissatisfaction […] There is most likely not one patient that has three correct and congruent medication lists. The consequences can be potentially catastrophic.”

**HCA’s Hospice Marketing**

HCA facilities undertake interesting methods to market hospice services to prospective patients. For example, Medical City Denton’s Professional Office Building in Texas hosted an event on advance directives. Participants were given forms to complete/finalize a living will and medical power of attorney, then and there, at no cost. Door prizes were also offered to attendees.
HCA’s Patient Discharge Breakdowns

HCA CEO Sam Hazen has suggested that post-acute services, such as hospice, are a means to facilitate better “throughput” and to create “efficiencies” within its hospitals. What does that actually mean? Most importantly, how do patients and their loved ones/representatives experience these so-called “efficiencies” in terms of patient care? CMS Statements of Deficiency provide some compelling insight.

Some HCA facilities may be in such a rush to shift patients out of their hospitals that patients may be unsafely discharged to post-acute settings of care, discharged to a setting not agreed to by the patient or the patient’s family/rep, or may even be discharged from the hospital without an order from the attending physician. A sampling of such discharge planning breakdowns are included below:

Unsafe Discharge of Patients

- On 10/17/2018, Eastern Idaho Regional Medical Center in ID was cited by CMS surveyors for deficiencies related to discharge planning. Specifically, CMS found that “the hospital failed to develop a system to identify patients who were likely to suffer adverse health consequences upon discharge if there was not adequate discharge planning. This failure affected 10 of 10 patients whose records were reviewed for discharge risk screening.” CMS interview with the Director of Case Management revealed that every patient admitted to the hospital received a discharge risk screening by an RN Case Manager. She stated the information reviewed by the RN Case Manager included admitting diagnosis, age, insurance, home address, and medical equipment used. CMS found that it could not be determined how other criteria listed on the hospital’s policy was determined, such as suspected abuse or neglect, financial concerns, multiple visits to the ED [Emergency Department], multiple hospital admissions, or patients receiving home health or hospice services.

- On 7/26/2019, HCA Florida Mercy Hospital in FL was cited by CMS for “fail[ing] to include the likelihood of a patient’s capacity for self-care in the environment from which the patient came when the patient entered the hospital.” CMS surveyors reference a case in which an elderly patient was transferred from another acute hospital and admitted to Mercy’s Behavioral Health Unit. CMS interview with the VP of Quality Management revealed that “this patient fell twice […] was on 1:1 most of her admission. She stated this patient was utilizing a wheelchair while an inpatient.” An interview with the Psychiatrist revealed that during this patient’s admission, “she was on 1:1, falling, not walking and in a wheelchair, very weak, participating in groups and at times agitated. She was discharged home with home health care. She stated the placement was inadequate, but they did send her home with home health follow up. She stated that she knew that home health was not sufficient for the patient [...]” The patient was later admitted to another acute hospital for medical care as she was declining and unable to care for self and her neighbor called 911.

- On 10/27/2021, Henrico’s Doctor’s Hospital in VA was cited by CMS for failing to “perform a safe discharge in ensuring the appropriate provision and transmission of patient information by not notifying the post-hospital facility that a patient was sent to be admitted...” The
patient, who was admitted from a psychiatric assisted living facility (ALF), was ordered to be discharged back to the ALF. However, the nurse manager confirmed they did not contact the ALF, nor could they provide any Emergency Department (ED) staff who did contact the facility regarding the discharge plan. The Director of Case Management also confirmed that there was no documentation in the patient’s clinical record that facility staff had called the ALF about the patient being dropped off at the facility. 67

Patients Discharged to the Wrong Location

- On 1/18/2019, HCA Florida Bayonet Point Hospital in FL was cited by CMS for failing to implement and keep the family/legal representative informed of the discharge plan for three patients (of five medical records sampled). In one case, a patient was discharged to a skilled nursing facility (SNF) other than the one specified by the patient’s daughter. CMS interview with the Director of Case Management revealed “the facility failed to implement Patient #3’s DC plan and ensure the family/legal representative was informed of the SNF change. The CM Director also confirmed CM failed to document the patient’s daughter/legal representative was made aware the patient was DC’d from the facility.” 68

- On 2/26/2019, HCA Houston Healthcare Northwest in TX was cited by CMS surveyors for failing to: “Provide an effective and safe transition from the hospital to the SNF [skilled nursing facility] for patient #1,” as the patient was transferred to the wrong SNF. CMS interview with a case manager revealed, “Staff #6 said they receive[d] a call from patient #1 daughter asking where is my father he is not here at Park Manor Cypress Station. After making calls, patient #1 was found at Park Manor Cy Fair, the wrong SNF. Staff #6 said she investigated but didn’t know if EMS drivers got the addresses mixed up or the staff.” Staff #6 further stated “they do not have a policy for discharges to SNF. The process is for case managers to complete an MOT form, place in the medical record so the nurse completing the discharge can give report to the receiving facility, give the room number to EMS.” 69

- On 3/26/19, HCA Florida Northwest Hospital in FL was cited by CMS for failing to reassess a discharge plan for a patient, “as evidenced by discharging Patient #1 out of the hospital while a discharge appeal was in process.” CMS references a case in which a patient’s sibling was appealing the discharge arrangements agreed to by the patient’s spouse because the “sibling wants patient to stay in the hospital to receive therapy until ready to go home.” But the Director of Case Management confirmed “there was no documentation in the clinical record stating Patient #1’s sibling had any rights to be making discharge plan decisions.” Yet the discharge wishes of both the patient’s spouse and sibling were not honored by the facility. CMS interview with the patient’s sibling revealed “they were not aware she was being transferred to SNF ‘3’ and they were very upset when they found out. He stated when his brother in law called the hospital around 4:30 PM to ask the nurse about a special drink and was told Patient #1 was discharged an hour and a half ago [...]. He stated Patient #1 had no mental capacity to agree to the transfer.” 70

- On 8/29/2018, Medical City Plano in TX was cited by CMS for failing to “ensure appropriate discharge within the geographic area of the patient’s residence, in that, Patient #4’s discharge plan referred the patient to (Another) County Hospital Services other than her county, Grayson County.” The CMS surveyor asked Personnel #22 “if the patient needed a transfer to (County Hospital) versus Discharge. Personnel #22 stated, ‘No. She needed
recommendations. Personnel #22 was asked if the discharge was appropriate given the geographic area of her residents. Personnel #22 stated, 'No. We ID’d that as an issue/opportunity.' 71

Discharged without Attending Physician’s Order

- On 1/7/21, HCA Florida Pasadena Hospital in FL was cited by CMS for failing to ensure the admitting physician provided a discharge order for a nursing home patient. CMS review of the medical record revealed the patient was admitted to the service of Physician A. While a discharge order was written by Consulting Physician B, there was no evidence Physician A wrote a discharge order - even though the "Medical Staff Rules and Regulations, Article I, Section 14, 'Discharge of Patients,' states patients shall be discharged on order by the attending practitioner." The CMS surveyor’s interview with the VP of Quality and Patient Safety and the Risk Manager confirmed these findings. 72

Recommendations

Like any other medical service, the decision to provide hospice care should be made by a qualified medical professional using their best clinical judgment, and by informed patients or patient guardians who agree to receive these services. Perhaps more than the average medical service, however, hospice service determinations particularly need to reflect compassion for patients and their families, as this service is only intended for patients whose disease is expected to end their life soon. The allegations and findings discussed in this paper provide significant reasons to worry that these decisions within HCA hospitals may be affected by factors outside of clinical judgment, and they may be made with far less compassion than they should be.

Given that these are often literally life and death decisions, we believe investigation into these HCA practices should begin immediately, and particularly by HCA itself. Patients, communities, and regulators deserve explanations of why the hospice transfer patterns appear to differ so much between HCA and national trends, and they deserve to know whether these transfer decisions are being made too aggressively, or are in any other way being made inappropriately.

We further call on federal and state regulators to begin their own inquiries into the system’s hospice transfer behavior as soon as possible. Whether the system’s apparent deviation has medically appropriate explanations behind it or not, the potential impact of inappropriate hospice transfer decisions is too strong for any investigations to be delayed until after HCA has performed its own.
8. TriStar Centennial Medical Center, CMS Form 2567 Statement of Deficiency, inspection date: 12/12/2018 , event ID: R6WK11, Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals, Full Text Statements of Deficiencies Hospital Surveys. All content in this subsection is drawn from this Statement of Deficiency.
11. From Dr. Singh’s LinkedIn profile. See https://www.linkedin.com/in/pariksith-singh-7b71322a
15. Complaint, Potdar v. HCA Healthcare, Inc., et al (No: 8:2018cv01928, M.D. Fla., 8/6/18) p16-17, par. 48
34. HCA Healthcare, Inc. SEC Schedule 14A, 2023 Proxy Statement for Annual Meeting of Stockholders, retrieved from https://www.sec.gov/Archives/edgar/data/860730/000119312523067645/d374683def14a.htm#toc374683_38,p66


39. HCA Healthcare, Inc. SEC Schedule 14A, 2023 Proxy Statement for Annual Meeting of Stockholders, retrieved from https://www.sec.gov/Archives/edgar/data/860730/000119312523067645/d374683dddef14a.htm#toc374683_38, p68


42. SEIU analyzed claim data for short-term general acute care hospitals and critical access hospitals from the annual Medicare Inpatient Standard Analytical File ("SAF"). Hospital discharges were identified as having hospice transfers if corresponding hospice claims for the patients were found within the Medicare Hospice SAF that began on the same day as hospital discharge. Hospitals with too few claims in a given year were excluded from analysis. Further methodology can be provided.

43. Hospitals are included as part of HCA in our analysis upon acquisition by HCA, and they are removed from HCA upon their divestiture from the system.


49. https://riversidecommunityhospital.com/specialties/hospice-family-care


52. https://stdavids.com/specialties/hospice-family-care


65. January 11, 2018, FUTURE BOOKINGS. Denton Record-Chronicle
70. HCA Florida Bayonet Hospital, CMS Form 2576 Statement of Deficiency, inspection date: 1/18/2019, event ID: BB1211, Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals, Full Text Statements of Deficiencies Hospital Surveys.
73. Medical City Plano, CMS Form 2576 Statement of Deficiency, inspection date: 8/29/18, event ID: WP7611, Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals, Full Text Statements of Deficiencies Hospital Surveys.

74. HCA Florida Pasadena Hospital, CMS Form 2576 Statement of Deficiency, inspection date: 1/7/21, event ID: KMO811, Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals, Full Text Statements of Deficiencies Hospital Surveys.