



Hospice

Program for Evaluating Payment
Patterns Electronic Report

User's Guide
Eleventh Edition

Hospice
Program for Evaluating Payment Patterns Electronic Report User’s Guide
Eleventh Edition, effective with the Q4FY21 release

What’s new in this edition?.....	3
Introduction.....	4
What Is PEPPER?	4
<i>Hospice PEPPER</i> CMS Target Areas.....	6
How Hospices Can Use PEPPER Data.....	10
Using PEPPER.....	14
Compare Targets Report.....	14
Target Area Reports.....	15
Hospice Top Terminal Diagnoses Report.....	16
Jurisdiction-Wide Terminal Diagnoses Report.....	17
Hospice Live Discharges by Type Report	17
Jurisdiction-Wide Live Discharges by Type Report.....	17
System Requirements, Customer Support, and Technical Assistance	18
Glossary	19
Acronyms and Abbreviations	21

What's new in this edition?

- Three new target areas were added:
 - *Average Number of Medicare Part D Claims for Beneficiaries Residing at Home*
 - *Average Number of Medicare Part D Claims for Beneficiaries Residing in an Assisted Living Facility*
 - *Average Number of Medicare Part D Claims for Beneficiaries Residing in a Nursing Facility*
- One target area was deleted: *Average Number of Medicare Part D Claims per Hospice Episode.*

Introduction

The Government Accountability Office designated Medicare as a program at high risk for fraud, waste, and abuse.¹ Medicare spending for hospice care has increased dramatically in recent years.² The Medicare hospice benefit has been identified as vulnerable to abuse; in 1999 the Office of Inspector General (OIG) encouraged hospices to develop and implement a compliance program to protect their operations from fraud and abuse.³ As part of its compliance program, a hospice should conduct regular audits to ensure charges for Medicare services are correctly documented and billed. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) can help guide hospices' auditing and monitoring activities.

What Is PEPPER?

National hospice claims data was analyzed to identify areas within the hospice benefit, which could be at risk for improper Medicare payment. These areas are referred to as "target areas." PEPPER is a data report that contains a single hospice's claims data statistics (obtained from the UB-04 claims submitted to the Medicare Administrative Contractor [MAC]) for these target areas. Each hospice receives a PEPPER, which contains statistics for these target areas, regardless of whether the hospice's data are of concern. The report shows how a hospice's data compares to national, jurisdiction, and state statistics. Data in PEPPER is presented in tabular form and in graphs that depict the hospice's target area percentages over time. All of the data tables, graphs, and reports in PEPPER were designed to assist hospices with the identification of potentially improper payments. PEPPER is developed and distributed by the RELI Group, along with its partners TMF® Health Quality Institute and CGS, under contract with the Centers for Medicare & Medicaid Services (CMS).

PEPPER has been available for hospices since 2012. PEPPERS are also available for short- and long-term acute care inpatient prospective payment system hospitals, critical access hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, partial hospitalization programs, skilled nursing facilities

PEPPER does not identify the presence of improper payments, but it can be used as a guide for auditing and monitoring efforts. A hospice can use PEPPER to compare its claims data over time to identify areas of potential concern and to identify changes in billing practices.

(SNFs), and home health agencies (the format of the reports and the target areas are customized for each setting). The *Hospice PEPPER* is the version of PEPPER specifically developed for hospices. The *Hospice PEPPER* is available to the hospice's Chief Executive Officer, Administrator, President, Quality Assurance and Performance Improvement Officer, or Compliance Officer through a secure portal on the PEPPER.CBRPEPPER.org website.

Each hospice receives only its PEPPER. The PEPPER Team does not provide PEPPERS to other contractors, although the PEPPER Team does provide a Microsoft Access

¹ Government Accountability Office. "Medicare Fraud, Waste and Abuse: Challenges and Strategies for Preventing Improper Payments." June 15, 2012. Available at: <http://www.gao.gov/new.items/d10844t.pdf>.

² Medicare Payment Advisory Commission. "Report to the Congress: Medicare Payment Policy." March 2012. Chapter 11, 281-308. Available at: <http://www.medpac.gov/docs/default-source/reports/chapter-11-hospice-services-march-2012-report-.pdf?sfvrsn=0>

³ Department of Health and Human Services/Office of Inspector General. 1999. "Publication of the OIG Compliance Program, Guidance for Hospices," *Federal Register* 64, no. 192, October 5, 1999, 54031–54049. Available at: <https://oig.hhs.gov/authorities/docs/hospicx.pdf>

database (the First-Look Analysis Tool for Hospital Outlier Monitoring [FATHOM]) to MACs and Recovery Auditors. FATHOM can be used to produce a PEPPER.

Hospices provide palliative care and support services for terminally ill beneficiaries who have a life expectancy of six months or less, should the terminal illness follows its normal course. Beneficiaries must elect the Medicare hospice benefit; in doing so, beneficiaries agree to forgo Medicare coverage for curative treatment for the terminal illness and related conditions.

Each *Hospice PEPPER* summarizes claims data statistics (obtained from paid hospice Medicare UB-04 claims) for the most recent three federal fiscal years (the federal fiscal year spans Oct. 1 through Sept. 30). A hospice is compared to other hospices in three comparison groups: the nation, MAC jurisdiction, and state. These comparisons enable a hospice to determine whether its results differ from other hospices and whether it is at risk for improper Medicare payments.

PEPPER identifies areas at risk for improper Medicare payments based on preset control limits. The upper control limit for all target areas is the national 80th percentile. Coding-focused target areas also have a lower control limit, which is the national 20th percentile. Note that the *Hospice PEPPER* does not contain any coding-focused target areas; therefore, the *Hospice PEPPER* draws attention to any findings that are at or above the national 80th percentile.

In order to be included in the *Hospice PEPPER*, claims must meet the specifications shown below.

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
Claim facility type equal to "8"	UB-04 Form Locator (FL) 04 Type of Bill, second digit (Type of Facility) = 8 (Special facility or ASC surgery)
Include claim service classification type of "Hospice"	UB-04 FL 04 Type of Bill, third digit (Bill Classification) = 1 (Hospice [non-hospital based]) or 2 (Hospice [hospital based])
Final action claim	A final action claim is a non-rejected claim for which a payment has been made. All disputes and adjustments have been resolved and details clarified.
Services provided during the time period used to create the episode of service	Claim "From Date" and claim "Through Date" fall within the three fiscal years included in the report. Additional claims for the two previous years will be included for episodes of service beginning prior to the reporting period. See below for more explanation of the episode of service.
Medicare claim payment amount greater than zero	The hospice received a payment amount greater than zero on the claim (Note that Medicare Secondary Payer claims are included)
Exclude Health Maintenance Organization claims	Exclude claims submitted to a Medicare Advantage (Health Maintenance Organization) plan
Exclude cancelled claims	Exclude claims cancelled by the MAC
Exclude claims for the Medicare Care Choices Model	Exclude claims with Treatment Authorization code = 73

To be eligible for the hospice benefit, the beneficiary must be terminally ill with a life expectancy of six months or less should the illness run its normal course. A beneficiary may receive hospice services for varying lengths of time that are represented by one or multiple claims. The PEPPER target areas were designed to report on the services provided during the specified time period (the federal fiscal year). Claims-based target areas summarize statistics for claims ending in the report period. Episode-based target areas report on services provided to beneficiaries whose episodes of service end during the report period. An episode of service is created from the claims submitted by a provider for each beneficiary as follows:

- All claims submitted by a hospice for a beneficiary are collected and sorted from the earliest “Claim From” date to the latest.
- If the latest claim in a series indicates that the beneficiary was discharged or did not return for continued care within 60 days, then that beneficiary’s episode of service is included in the time/report period in which the latest “Through Date” falls.
- If the latest claim in the series ended in the last sixty days of the time/report period (e.g., Aug. 2 – Sept. 30, 2019, for the Q4FY19 release) and indicates that the beneficiary was still a patient (patient discharge status code “30”), then that beneficiary’s episode of service is not included.
- If there is a gap between one claim’s “Through Date” to the next claim’s “From Date” of more than 60 days, then that is considered the ending of one episode of service and the beginning of a new episode of service.
- Each episode of service is included in the time/report period in which the latest “Through Date” falls.
- Claims are collected for two years prior to each time period so that the longer lengths of stay (LOSs) may be evaluated.

Hospice PEPPER CMS Target Areas

In general, the target areas are constructed as ratios and expressed as percents; the numerator represents episodes or days of service that may be identified as problematic in terms of risk for improper Medicare payment, and the denominator represents episodes or days of service of a larger comparison group. The *Hospice PEPPER* target areas are defined in the table below.

TARGET AREA	TARGET AREA DEFINITION
Live Discharges No Longer Terminally Ill	<p><i>Numerator (N):</i> count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to 40 [expired at home], 41 [expired in a medical facility], or 42 [expired place unknown]), excluding:</p> <ul style="list-style-type: none"> • beneficiary transfers (patient discharge status code 50 or 51) • beneficiary revocations (occurrence code 42) • beneficiaries discharged for cause (condition code H2) • beneficiaries who moved out of the service area (condition code 52) <p><i>Denominator (D):</i> count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)</p>
Live Discharges – Revocations	<p><i>N:</i> count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to 40 [expired at home], 41 [expired in a medical facility], or 42 [expired place unknown]), with occurrence code 42</p> <p><i>D:</i> count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)</p>
Live Discharges with LOS 61 – 179 Days	<p><i>N:</i> count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to 40 [expired at home], 41 [expired in a medical facility], or 42 [expired place unknown]), with a LOS of 61 – 179 days</p> <p><i>D:</i> count of all beneficiary episodes discharged alive by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)</p>

TARGET AREA	TARGET AREA DEFINITION
Long Length of Stay	<p><i>N</i>: count of beneficiary episodes discharged (by death or alive) by the hospice during the report period whose combined days of service at the hospice is greater than 180 days (obtained by considering all claims billed for a beneficiary by that hospice)</p> <p><i>D</i>: count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)</p>
Continuous Home Care Provided in an Assisted Living Facility	<p><i>N</i>: count of beneficiary episodes discharged (by death or alive) by the hospice during the report period where at least eight hours of Continuous Home Care (CHC) (revenue code = 0652) were provided while the beneficiary resided in an Assisted Living Facility (ALF) (Healthcare Common Procedure Coding System [HCPCS] code = Q5002)</p> <p><i>D</i>: count of all beneficiary episodes ending in the report period that indicate the beneficiary resided in an ALF (HCPCS code = Q5002) for any portion of the episode</p>
Routine Home Care Provided in an Assisted Living Facility	<p><i>N</i>: count of Routine Home Care (RHC) days (revenue code = 0651) provided on claims ending in the report period that indicate the beneficiary resided in an ALF (HCPCS code = Q5002)</p> <p><i>D</i>: count of all RHC days (revenue code = 0651) provided by the hospice on claims ending in the report period</p>
Routine Home Care Provided in a Nursing Facility	<p><i>N</i>: count of RHC days (revenue code = 0651) provided on claims ending in the report period that indicate the beneficiary resided in a nursing facility (NF) (HCPCS code = Q5003)</p> <p><i>D</i>: count of all RHC days (revenue code = 0651) provided by the hospice on claims ending in the report period</p>
Routine Home Care Provided in a Skilled Nursing Facility	<p><i>N</i>: count of RHC days (revenue code = 0651) provided on claims ending in the report period that indicate the beneficiary resided in a SNF (HCPCS code = Q5004)</p> <p><i>D</i>: count of all RHC days (revenue code = 0651) provided by the hospice on claims ending in the report period</p>
Claims with Single Diagnosis Coded	<p><i>N</i>: count of claims ending in the report period that have only one diagnosis coded</p> <p><i>D</i>: count of all claims ending in the report period with one or more diagnoses coded</p>
No General Inpatient Care or Continuous Home Care	<p><i>N</i>: count of beneficiary episodes ending in the report period that had no amount of general inpatient care (revenue code = 0656) or CHC (revenue code = 0652)</p> <p><i>D</i>: count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)</p>
Long General Inpatient Care Stays	<p><i>N</i>: count of General Inpatient Care (GIP) stays within episodes ending in the report period with a length greater than five consecutive days</p> <p><i>D</i>: count of all GIP stays within episodes ending in the report period, identified as 1+ consecutive days of revenue code 0656</p>

TARGET AREA	TARGET AREA DEFINITION
Average Number of Medicare Part D Claims for Beneficiaries Residing at Home (new as of Q4FY21)	<i>N</i> : count of Medicare Part D claims for beneficiaries residing at home during a hospice episode of at least three days <i>D</i> : count of hospice episodes of at least three days for beneficiaries residing at home Note: reported as a rate, not a percent
Average Number of Medicare Part D Claims for Beneficiaries Residing in an Assisted Living Facility (new as of Q4FY21)	<i>N</i> : count of Medicare Part D Claims for beneficiaries residing in an ALF during a hospice episode of at least three days <i>D</i> : count of hospice episodes of at least three days for beneficiaries residing in an ALF Note: reported as a rate, not a percent
Average Number of Medicare Part D Claims for Beneficiaries Residing in a Nursing Facility (new as of Q4FY21)	<i>N</i> : count of Medicare Part D claims for beneficiaries residing in an NF during a hospice episode of at least three days <i>D</i> : count of hospice episodes of at least three days for beneficiaries residing in an NF Note: reported as a rate, not a percent

These PEPPER target areas were approved by CMS because they have been identified as being potentially at risk for improper Medicare payments.

The hospice benefit is designed to provide palliative and supportive care for terminally ill beneficiaries. Beneficiaries may be discharged alive from hospice care for the following reasons:

- The beneficiary is determined to be no longer terminally ill
- The beneficiary moves out of the service area
- The beneficiary is discharged for cause
- The beneficiary revokes the hospice benefit

Hospices that discharge alive a high proportion of beneficiaries from the hospice benefit may be admitting beneficiaries who do not meet the hospice eligibility criteria. This may also be an indication of quality of care concerns or that financial concerns are driving hospice services. All three target areas addressing live discharges focus on these issues.

A beneficiary may choose to revoke the election of hospice care at any time and may re-elect to receive hospice coverage at a later time. The hospice cannot revoke the beneficiary’s election. The hospice cannot request nor demand the beneficiary revoke his/her election. CMS has identified concerns related to patterns of revocations and elections of the Medicare hospice benefit for the purpose of potentially avoiding costly hospitalizations and/or expensive procedures, drugs, or services. Patterns of discharge, hospital admission, and hospice readmission do not provide a comprehensive, coordinated care experience for terminally ill patients. Thus, there is a target area focused on live discharges for beneficiary revocations.

As of Oct. 1, 2015 (fiscal year 2016), CMS implemented a higher RHC payment rate for the first 60 days of care, after which the RHC payment rate decreases. This change in payment rates may be an incentive for hospices to discharge patients after the first 60 days (once the lower payment rate takes effect).

Therefore, there is a target area to monitor the percent of all beneficiaries discharged alive with a LOS of 61 – 179 days. Hospices that have a high proportion of beneficiaries with a long LOS may be admitting beneficiaries who do not meet the hospice eligibility criteria. In addition, the Medicare Payment Advisory Commission (MedPAC) raised concerns regarding longer LOSs and higher frequencies of patients being discharged alive from hospices.⁴ The hospice average length of stay (ALOS) has not changed significantly over the past few years.⁵

The OIG reviewed hospice services provided to beneficiaries residing in ALFs.⁶ The OIG found concerns relating to overutilization of hospice services for beneficiaries residing in an ALF. Hospice services for beneficiaries residing in a SNF or NF are also at risk for overutilization. Therefore, there are target areas focusing on these concerns.

Hospice claims should include the appropriate selection of principal diagnoses as well as other additional and coexisting diagnoses related to the terminal illness and related conditions. Coding guidelines specify that “all of a patient’s coexisting or additional diagnoses” related to the terminal illness and related conditions should be reported on the hospice claim. The expectation is that hospices report all diagnoses related to the terminal illness and related conditions on the hospice claim to provide accurate information regarding the hospice beneficiaries receiving services at the hospice. To address this concern, there is a target area focused on the percentage of claims with only one diagnosis coded. Note: As of Oct. 1, 2014, “debility,” “adult failure to thrive,” and several dementia diagnosis codes will not be accepted as principal hospice diagnoses on a hospice claim form. When any of these diagnoses are reported as a principal diagnosis, the claim will be returned to the provider for a more definitive hospice diagnosis based on International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Coding Guidelines.⁷

Medicare Conditions of Participation require hospices to demonstrate that they are able to provide all four levels of care (i.e., RHC, GIP, CHC, and inpatient respite care) to be a certified Medicare hospice provider. CMS found that 77% of beneficiaries did not have any GIP care and that 57% of hospices did not bill at least one day of CHC in 2012.⁸ While there are appropriate circumstances where a hospice provides no GIP or no CHC, there is a concern that beneficiaries may not have adequate access to the necessary level of care. Additionally, there is the risk that the level of hospice care that a beneficiary

⁴ Medicare Payment Advisory Commission. “Report to Congress: Medicare and the Health Care Delivery System.” Available at: http://medpac.gov/docs/default-source/reports/jun13_entirereport.pdf

⁵ Medicare Payment Advisory Commission. “Report to Congress: Medicare Payment Policy.” March 2019. Available at: http://www.medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf

⁶ Department of Health and Human Services/Office of Inspector General, 2015. “Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities.” January 2015. Available at: <https://oig.hhs.gov/oei/reports/oei-02-14-00070.pdf>

⁷ The Centers for Medicare & Medicaid Services. “MLN Matters 8877.” Aug. 8, 2014. Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8877.pdf>

⁸ Department of Health and Human Services/The Centers for Medicare & Medicaid Services. 2014. “FY2015 Hospice Final Rule.” *Federal Register* 79, no. 165, Aug. 22, 2014. Available at: <https://www.govinfo.gov/content/pkg/FR-2014-08-22/pdf/2014-18506.pdf>

receives may not always be driven by patient factors. Therefore, there is a target area assessing the percentage of episodes of care where the beneficiary does not receive any GIP or CHC.

The OIG reviewed hospice GIP stays and found concerns relating to inappropriate use of GIP.⁹ (GIP is intended to be short-term and may be provided in a hospice inpatient unit, hospital, or SNF for pain control or acute/chronic symptom management that cannot be addressed in other settings (e.g., the beneficiary's home). When a beneficiary has a long GIP stay the concern is whether GIP is the appropriate level of care and whether the beneficiary's symptoms are being effectively managed by the hospice. Therefore, there is a target area focused on long GIP stays.

In August 2019, the Office of Inspector General (OIG) released a report entitled *Medicare Part D Is Still Paying Millions for Drugs Already Paid for Under the Part A Hospice Benefit*, which detailed concerns and improper payments related to Medicare spending outside of the hospice benefit.¹⁰ The OIG estimated that the Medicare Part D total cost was \$160.8 million for drugs that should have been paid for by hospice organizations. There are three target areas related to this topic, each of which is differentiated by the location in which a beneficiary resided. The place of service indicated on the last claim in a hospice episode was used to determine the place of residence for the beneficiary. A hospice episode had to be at least three days in length to be assessed. Medicare Part D claims were counted beginning on the day after the first day of the episode. If the discharge status of the beneficiary was expired, then the Medicare Part D claims were counted to the last day of the episode. However, if the beneficiary was discharged alive, the Medicare Part D claims were counted until one day before the day of discharge, which is the last day of the episode. A hospice with a high average number of Part D claims per episode may need to examine their policies for provision of drugs to hospice patients.

How Hospices Can Use PEPPER Data

The *Hospice PEPPER* allows hospices to compare their billing statistics with national, jurisdiction, and state percentile values for each target area with reportable data for the most recent three fiscal years included in PEPPER.

To calculate percentiles, the target area percents/rates for all hospices with reportable data for each target area and each time period are ordered from highest to lowest. The target area percent/rate below which 80% of all hospices' target area percents/rates fall is identified as the 80th percentile. Hospices whose target percents/rates are at or above the 80th percentile (i.e., the top 20%) are considered at risk for improper Medicare payments. Percentiles are calculated for each of the three

"Reportable data" in PEPPER means the numerator or denominator count is at least 11 for a given target area for a given time period. When the numerator or denominator count is less than 11 for a target area for a time period, statistics are not displayed in PEPPER due to CMS data restrictions.

⁹ Department of Health and Human Services/Office of Inspector General, 2015. "Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care." January 2015. Available at: <https://oig.hhs.gov/oei/reports/oei-02-14-00070.pdf>

¹⁰ Department of Health and Human Services/Office of Inspector General, 2019. "Medicare Part D is Still Paying Millions for Drugs Already Paid for Under the Part A Hospice Benefit." August 2019. Available at: <https://oig.hhs.gov/oas/reports/region6/61708004.pdf>

comparison groups (i.e., nation, jurisdiction, and state). The greater the hospices' percentile, the greater risk for improper payments.

The PEPPER Team has developed suggested interventions that hospices could consider when assessing their risk for improper Medicare payments. Please note that these are generalized suggestions and will not apply to all situations. The following table can assist hospices with interpreting their percentile values, which are indications of possible risk of improper Medicare payments.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HOSPICES AT RISK FOR IMPROPER PAYMENTS (IF AT/ABOVE 80 TH PERCENTILE)
<p><i>Live Discharges No Longer Terminally Ill</i></p> <p><i>Live Discharges – Revocations</i></p> <p><i>Live Discharges with LOS 61 – 179 Days</i></p>	<p>For all three target areas related to live discharges: This could indicate that beneficiaries are being enrolled in the Medicare hospice benefit who do not meet the hospice eligibility criteria. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit when they meet eligibility criteria. Medical record documentation should be reviewed for beneficiaries discharged alive to determine whether enrollment in the hospice benefit was appropriate and in accordance with Medicare policy.</p> <p>For revocations: A high percentage of live discharges for beneficiary revocations could indicate improper beneficiary revocations are occurring. The hospice should review instances where occurrence code 42 is applied to ensure that the revocation was initiated by the beneficiary (not by the hospice) and that the revocation was not initiated to avoid costly patient care.</p> <p>For LOS 61 – 179: As of Oct. 1, 2015 (fiscal year 2016), hospice payments for RHC decreased on day 61. Beginning with FY2016, a high percentage of live discharges with a LOS between 61 and 179 days could indicate that financial incentives are impacting patient care decisions.</p>
<p><i>Long Length of Stay</i></p>	<p>This could indicate that beneficiaries are being enrolled in the Medicare hospice benefit who do not meet the hospice eligibility criteria. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit when they meet eligibility criteria. Medical record documentation should be reviewed for a sample of beneficiaries with long LOSs to determine whether enrollment in the hospice benefit was appropriate and in accordance with Medicare policy.</p>
<p><i>Continuous Home Care Provided in an Assisted Living Facility</i></p>	<p>This could indicate that beneficiaries who reside in an ALF are being enrolled in the Medicare hospice benefit when they may not meet hospice eligibility criteria or that the hospice is providing a higher level of hospice service than is necessary to beneficiaries who reside in an ALF. The hospice should review documentation to ensure that beneficiaries are enrolled in the hospice benefit appropriately, that the level of hospice service is appropriate and in accordance with Medicare policy, and that the number of hours of CHC billed are supported by documentation in the medical record.</p>
<p><i>Routine Home Care Provided in an Assisted Living Facility</i></p>	<p>This could indicate that beneficiaries who reside in an ALF are being enrolled in the Medicare hospice benefit when they may not meet hospice eligibility criteria. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit appropriately. Medical record documentation should be reviewed to determine whether enrollment in the hospice benefit and services provided are appropriate and in accordance with Medicare policy.</p>

TARGET AREA	SUGGESTED INTERVENTIONS FOR HOSPICES AT RISK FOR IMPROPER PAYMENTS (IF AT/ABOVE 80 TH PERCENTILE)
<i>Routine Home Care Provided in a Nursing Facility</i>	This could indicate that beneficiaries who reside in a NF are being enrolled in the Medicare hospice benefit when they may not meet hospice eligibility criteria. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit appropriately. Medical record documentation should be reviewed to determine whether enrollment in the hospice benefit and services provided are appropriate and in accordance with Medicare policy.
<i>Routine Home Care Provided in a Skilled Nursing Facility</i>	This could indicate that beneficiaries who reside in a SNF are being enrolled in the Medicare hospice benefit when they may not meet hospice eligibility criteria. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit appropriately. Medical record documentation should be reviewed to determine whether enrollment in the hospice benefit and services provided are appropriate and in accordance with Medicare policy.
<i>Claims with Single Diagnosis Coded</i>	This could indicate that the hospice is not coding all coexisting diagnoses related to the terminal illness and related conditions. All of a patient's coexisting or additional diagnoses related to the terminal illness and related conditions should be reported on the hospice claim. The hospice should review a sample of hospice claims with a single diagnosis coded to ensure that all diagnoses related to the terminal illness and related conditions are reported on the hospice claim. Remember that in order for a diagnosis to be coded as a coexisting condition it must be substantiated by documentation. A coder should not code based on laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding. Consider whether the use of a physician query would have substantiated a coexisting condition.
<i>No General Inpatient Care or Continuous Home Care</i>	This could indicate that the hospice is not providing the full spectrum of services as required by the Medicare program. A sample of records for beneficiaries that did not receive GIP or CHC should be reviewed. The hospice should ensure that processes are in place to assess when beneficiaries need GIP and/or CHC and that the hospice is able to provide these services.
<i>Long General Inpatient Care Stays</i>	This could indicate that the hospice is initiating GIP services when not indicated/necessary. A sample of records for beneficiaries that had long GIP stays should be reviewed to determine whether GIP was provided in the appropriate setting and was appropriately used for pain control or acute/chronic symptom management that could not be addressed in other settings.

TARGET AREA	SUGGESTED INTERVENTIONS FOR HOSPICES AT RISK FOR IMPROPER PAYMENTS (IF AT/ABOVE 80 TH PERCENTILE)
<p><i>Average Number of Medicare Part D Claims for Beneficiaries Residing at Home</i></p> <p><i>Average Number of Medicare Part D Claims for Beneficiaries Residing in an Assisted Living Facility</i></p> <p><i>Average Number of Medicare Part D Claims for Beneficiaries Residing in a Nursing Facility</i></p> <p>(new as of the Q4FY21 release)</p>	<p>For all three target areas related to average number of Medicare Part D claims: This could indicate that patients residing at home, in ALFs, or in NFs may be receiving drugs that should have been paid for by the hospice organization. A sample of records for beneficiaries should be reviewed. The hospice should ensure that processes are in place to assess medication regimens and that medications related to the terminal condition are provided as part of the hospice benefit. It is recommended that the hospice compare the rate of claims for beneficiaries residing in different settings, in order to identify the patient population with the highest rate so that it may be prioritized for possible intervention.</p>

Comparative data for the three consecutive years can be used to help identify whether the hospice’s target area percents/rates changed significantly in either direction from one year to the next. This could be an indication of a procedural change in admitting practices, staff turnover, or a change in medical staff.

Using PEPPER

Compare Targets Report

Hospices can use the Compare Targets Report to help prioritize areas for auditing and monitoring. The Compare Targets Report includes all target areas with reportable data for the most recent year included in PEPPER. For each target area, the Compare Targets Report displays the hospice's number of target episodes, percent, hospice percentiles as compared to the nation, jurisdiction, and state, and the "Sum of Payments" (where calculated).

Navigate through PEPPER by clicking on the worksheet tabs at the bottom of the screen. Each tab is labeled to identify the contents of each worksheet (e.g., Target Area Reports, Compare Targets Report).

The *Hospice PEPPER* identifies providers whose data results suggest they are at risk for improper Medicare payments as compared to all hospices in the nation. The hospice's risk status is indicated by the color of the target area percent/rate on the Compare Targets Report. When the hospice's percent/rate is at or above the national 80th percentile for a target area, the

hospice's percent/rate is printed in **red bold**. When the hospice's percent/rate is below the national 80th percentile, the hospice's percent/rate is printed in black.

The Compare Targets Report provides the hospice's percentile value for the nation, jurisdiction, and state for all target areas with reportable data in the most recent year. The percentile value allows a hospice to judge how its target area percent/rate compares to all hospices in each respective comparison group. (See "Percentile" in the Glossary, page 19.)

The hospice's national percentile indicates the percentage of all other hospices in the nation that have a target area percent/rate less than the hospice's target area percent/rate.

The hospice's jurisdiction percentile indicates the percentage of all other hospices in the MAC jurisdiction that have a target area percent/rate less than the hospice's target area percent/rate. The hospice's jurisdiction percentile for a target area will be blank if there are fewer than 11 hospices with reportable data for the target area in the jurisdiction.

The hospice's state percentile indicates the percentage of all other hospices in the state that have a target area percent/rate less than the hospice's target area percent/rate. The hospice's state percentile for a target area will be blank if there are fewer than 11 hospices with reportable data for the target area in the state.

For more information about how percents differ from percentiles, see the "Training and Resources" page in the Hospice section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

When interpreting the Compare Targets Report findings, hospices should consider their target area percentile values for the nation, jurisdiction, and state. Percentile values at or above the 80th percentile indicate that the hospice is at risk for improper Medicare payments. Providers should place the highest priority with their national percentile, as this percentile represents how the hospice compares to all hospices in the nation.

Percentile values at or above the jurisdiction's 80th percentile or state's 80th percentile should be considered as well, though they should be considered as a lower priority. Jurisdiction and state are smaller

comparison groups; therefore, the percentiles for these groups may be less meaningful. In addition, there may be regional differences in practice patterns reflected in jurisdiction and state percentiles.

The “Sum of Payments” (calculated for target areas that are based on episodes) and “Target Count” can also be used to help prioritize areas for review. Areas in which a provider is at/above the 80th percentile that have a high sum of payment and/or number of target episodes may be given higher priority than target areas for which a provider is at/above the 80th percentile that have a lower sum of payments/number of target episodes.

Target Area Reports

PEPPER Target Area Reports display a variety of statistics for each target area summarized over three years. Each report includes a target area graph, a target area data table, comparative data, interpretive guidance, and suggested interventions.

Target Area Graph

Each report includes a target area graph, which provides a visual representation of the hospice’s target area percent/rate over three years. The hospice’s data is represented on the graph in bar format; each bar represents a fiscal year. Hospices can identify significant changes from one time period to the next, which could be a result of changes in medical staff or utilization review processes, for example. Hospices are encouraged to identify root causes of major changes to ensure that improper payments are prevented.

The graph includes red trend lines for the percents/rates that are at the 80th percentile for the three comparison groups (i.e., nation, jurisdiction, and state) so the hospice can easily identify when its results suggest that it is at risk for improper Medicare payments when compared to any of the comparison groups. A table of these percents/rates called “Comparative Data” is included under the hospice’s data table. For more information about how percents differ from percentiles, see the “Training and Resources” page in the Hospice section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

A hospice’s data will not be displayed in the graph if the numerator or denominator count for the target area is less than 11 for any time period. This is due to data restrictions established by CMS. If there are fewer than 11 hospices with reportable data for a target area in a state for any time period, there will not be a data point/trend line for the state comparison group in the graph. If there are fewer than 11 hospices with reportable data for a target area in a jurisdiction for any time period, there will not be a data point/trend line for the jurisdiction comparison group in the graph.

Target Area Hospice Data Table

PEPPER Target Area Reports also include a hospice data table. Statistics in each data table include the total number of episodes, claims or days of service for the target area (numerator count), the denominator count, and the proportion of the numerator and denominator (percent). For target areas calculated based on episodes, the ALOS for the numerator and for the denominator, along with the average and sum of Medicare payment data, are also calculated. Note that the numerator and denominator ALOS and the average and sum of Medicare payments are not calculated for the *Routine Home Care Provided in an Assisted Living Facility*, *Routine Home Care Provided in a Nursing Facility*, *Routine Home Care*

Provided in a Skilled Nursing Facility, Claims with Single Diagnosis Coded, and Long General Inpatient Care Stay target areas.

The hospice's percent/rate will be shown in **red bold print** if it is at or above the national 80th percentile, which suggests a risk of improper Medicare payments. (See "Percentile" in the Glossary, page 19) For each time period, a hospice's data will not be displayed if the numerator or denominator for the target area is less than 11.

Comparative Data Table

The comparative data table provides the target area percents/rates that are at the 80th percentile for the three comparison groups: the nation, jurisdiction, and state. These are the values that are graphed as trend lines on the Target Area Graph. State percentiles are zero when there are fewer than 11 hospices with reportable data for a target area in the state. Jurisdiction percentiles are zero when there are fewer than 11 hospices with reportable data for a target area in the jurisdiction.

Interpretive Guidance and Suggested Interventions

Interpretive guidance is included on the Target Area Report (below the graph) to assist hospices in considering whether they should audit a sample of records. Suggested interventions for providers, whose results suggest a risk for improper Medicare payments, are tailored to each target area and are included at the bottom of each Target Area Report.

Hospice Top Terminal Diagnoses Report

The Hospice Top Terminal Diagnoses Report lists the Clinical Classification Software (CCS) categories for hospice decedents (beneficiaries that died) for the most recent fiscal year. The terminal CCS diagnosis categories are as follows:

- Cancer (CCS categories 11 – 47)
- Circulatory or heart disease (CCS categories 96 – 108 and 114 – 121)
- Dementia (CCS category 653)
- Respiratory disease (CCS categories 127 – 134)
- Stroke (CCS categories 109 – 113)

To determine the CCS category, the principal diagnosis code from the final claim is collapsed into a general category using CCS. More information on CCS can be found at https://www.hcup-us.ahrq.gov/tools_software.jsp.

The report includes the total number of decedents for each of the top terminal condition categories, the proportion of decedents for each category to total hospice decedents and the hospice's ALOS for each category. ALOS is calculated by dividing the total number of days decedents in each terminal CCS category received services from the hospice by the total number of decedents in the CCS diagnosis category who received services from the hospice. Please note that this report is limited to the top terminal CCS diagnosis categories for which there are a total of at least 11 decedents during the most recent fiscal year.

Jurisdiction-Wide Terminal Diagnoses Report

The Jurisdiction Top Terminal Diagnoses Report lists the terminal condition categories for decedents (beneficiaries who died) in the jurisdiction for the most recent fiscal year. The terminal CCS diagnosis categories are as follows:

- Cancer (CCS categories 11 – 47)
- Circulatory or heart disease (CCS categories 96 – 108 and 114 – 121)
- Dementia (CCS category 653)
- Respiratory disease (CCS categories 127 – 134)
- Stroke (CCS categories 109 – 113)

To determine the CCS category, the principal diagnosis code from the final claim is collapsed into a general category using CCS. More information on CCS can be found at <http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp>.

The report includes the jurisdiction-wide total number of decedents for each of the top terminal condition categories, the proportion of decedents for each category to total decedents, and the jurisdiction's ALOS for each category. ALOS is calculated by dividing the total number of days decedents in each terminal CCS category received services by the total number of decedents in the CCS diagnosis category who received services in the jurisdiction. Please note that this report is limited to the top terminal CCS diagnosis categories for which there are a total of at least 11 decedents during the most recent fiscal year.

Hospice Live Discharges by Type Report

The Hospice Live Discharges by Type Report provides detailed information on episodes where the beneficiary was discharged alive in the most recent three fiscal years. A live discharge is identified when the patient discharge status code is not equal to 40 (expired at home), 41 (expired in a medical facility), or 42 (expired place unknown). Live discharges are categorized as follows:

- No longer terminally ill
- Revocation (occurrence code 42)
- Moved out of service area (condition code 52)
- Beneficiary transfer (discharge status code 50 or 51)
- Discharged for cause (condition code H2)

The report identifies the total number of episodes for each live discharge type in descending order by volume for the hospice for the most recent three fiscal years. It also displays the proportion of live discharges to total live discharges and the hospice's ALOS. ALOS is calculated by dividing the total number of days beneficiaries discharged alive received services from the hospice by the total number of live discharges. The hospice's overall proportion of all live discharges to total episodes (ending by death or alive) is also included, along with the hospice's ALOS for all live discharges. Please note that this report is limited to the types of live discharges for which there are a total of at least 11 episodes discharged alive at the hospice during the most recent three fiscal years.

Jurisdiction-Wide Live Discharges by Type Report

The Jurisdiction-Wide Live Discharges by Type Report provides detailed information on episodes where the beneficiary was discharged alive in the most recent three fiscal years for all hospices in the MAC jurisdiction (See specifications for live discharges above). The report identifies the total number of

episodes for each live discharge type in descending order by volume for the jurisdiction for the most recent three fiscal years. It also displays the proportion of live discharges to total live discharges and the jurisdiction's ALOS. ALOS is calculated by dividing the total number of days beneficiaries discharged alive received services by the total number of live discharges. The overall proportion of all live discharges to total episodes (ending by death or alive) in the jurisdiction is also included, along with the jurisdiction and national ALOS for all live discharges.

System Requirements, Customer Support, and Technical Assistance

PEPPER is a Microsoft Excel workbook that can be opened and saved to a PC. It is not intended for use on a network, but it may be saved to as many PCs as necessary.

For help using PEPPER, please submit a request for assistance at PEPPER.CBRPEPPER.org by clicking on the "Help/Contact Us" tab. This website also provides many educational resources to assist hospices with PEPPER in the Hospice "Training and Resources" section.

Please do **not** contact your state Medicare Quality Improvement Organization or any other organization for assistance with PEPPER, as these organizations are not involved in the production or distribution of PEPPER.

Glossary

TERM	DESCRIPTION
Average Length of Stay	The average length of stay (ALOS) is calculated as an arithmetic mean. It is computed by dividing the total number of days beneficiaries received service from the hospice by the total number of episodes of service within the time period.
Data Table	The statistical findings for a hospice are presented in tabular form, labeled by time period and indicator.
Episode of Service	An episode of service is created using claims submitted by a hospice. All claims submitted by a hospice for a beneficiary are collected and sorted from the earliest “Claim From” date to the latest. If the latest claim in a series indicates that the beneficiary was discharged or did not return for continued care within 60 days, then that beneficiary’s episode of service is included in the time/report period in which the latest “Through Date” falls. If the latest claim in the series ended in the last month of the time/report period (e.g., Sept. 1 – 30, 2019, for the Q4FY19 release) and indicates that the beneficiary was still a patient (patient discharge status code “30”), then that beneficiary’s episode of service is not included. If there is a gap between one claim’s “Through Date” to the next claim’s “From Date” of more than 60 days, then that is considered the ending of one episode of service and the beginning of a new episode of service. Each episode of service is included in the time/report period in which the latest “Through Date” falls. Claims are collected for two years prior to each time period so that the longer LOSs may be evaluated.
Fiscal Year	For Medicare data, the fiscal year starts on Oct. 1 and ends on Sept. 30.
Graph	In PEPPER, a graph shows a hospice’s percentages for three years. The hospice’s percentages are compared to the 80 th percentiles for the nation, jurisdiction, and state for all target areas. See <i>Percentile</i> .
Length of Stay	The length of stay (LOS) is the total number of hospice days for the series of claims submitted for a beneficiary’s episode of service. It is computed by first subtracting the admission date (i.e., from date) of the first claim in the episode of service from the discharge date (i.e., through date) of the last claim in the episode of service and then adding one.

TERM	DESCRIPTION
<p>Percentile</p>	<p>In PEPPER, the percentile represents the percent of hospices in the comparison group below which a given hospice’s percent/rate value ranks. It is a number that corresponds to one of 100 equal divisions of a range of values in a group. The percentile represents the hospice’s position in the group compared to all other hospices in the comparison group for that target area and time period. For example, suppose a hospice has a target area percent of 2.3 and 80% of the hospices in the comparison group have a percent for that target area that is less than 2.3. Then we can say the hospice is at the 80th percentile.</p> <p>Percentiles in PEPPER are calculated from the hospices’ percents/rates so that each hospice percent/rate can be compared to the statewide, jurisdiction-wide, or nationwide distribution of hospice percents/rates.</p> <p>For more information about how percents differ from percentiles, please see the “Training and Resources” page in the Hospice section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.</p>

Acronyms and Abbreviations

ACRONYM/ ABBREVIATION	ACRONYM/ABBREVIATION DEFINITION
ALF	Assisted living facility (ALF)
ALOS	The average length of stay (ALOS) is calculated as an arithmetic average or mean. It is computed by dividing the total number of days beneficiaries received service from the hospice by the total number of episodes of service within the given time period.
CCS	Clinical Classification Software (CCS)
CHC	Continuous Home Care (CHC)
CMS	The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for oversight of Medicare and Medicaid. CMS is a division of the U.S. Department of Health and Human Services.
FATHOM	First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) is a Microsoft Access application. It was designed to help MACs compare providers in areas at risk for improper payment using Medicare administrative claims data. FATHOM produces PEPPER.
FI	Fiscal intermediary (FI)
FY	Fiscal year (FY)
GIP	General inpatient care (GIP)
HCPCS	Healthcare Common Procedure Coding System (HCPCS)
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
LOS	Length of stay (LOS)
MAC	The Medicare Administrative Contractor (MAC) is the contracting authority that replaced the FI and carrier in performing Medicare Fee-for-Service claims processing activities.
MedPAC	Medicare Payment Advisory Commission (MedPAC)
NF	Nursing facility (NF)
OIG	Office of Inspector General (OIG)
PEPPER	Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a data report that contains a single hospice's claims data statistics for claims for service that are at risk for improper Medicare payments.
RHC	Routine home care (RHC)
UB-04	Standard uniform bill used by health care providers to submit claims for services. Claims for Medicare reimbursement are submitted to the provider's MAC.