In April, hospices will get more CMS data to use in their compliance monitoring, just in time for the debut of the first national recovery audit contractor (RAC) for hospice claims.

The expanded Program for Evaluating Payment Patterns Electronic Report (PEPPER) for hospices will hit the shelves in April. Coincidentally, that roughly coincides with the expected launch of the Region 5 RAC, which will audit Medicare claims for home health, hospice and durable medical equipment, prosthetic and orthotic supplies (DMEPOS). While PEPPER is a carrot to encourage compliance, the RAC is a stick, to capture overpayments that have not been voluntarily refunded by providers.

PEPPERs are free reports on billing rates in certain risk areas. They are designed to help hospitals, hospices and other providers tailor their compliance monitoring to outliers unique to their facilities. PEPPERs allow hospitals and hospices to compare their billing rates to those of their peers in the nation, in Medicare administrative contractor (MAC) jurisdictions and in states in the target areas. It’s a red flag when a hospice’s billing in a target area is at or above the national 80th percentile, which means it bills a higher percentage for that target area than 80% of all hospices nationally. That doesn’t necessarily mean there was an error, but it’s up to the hospices to determine whether they have a compliance issue or some reasonable explanation.

In 2012, PEPPERs were provided to hospices in two risk areas (RMC 8/13/12, p. 1). Now this is being expanded, at CMS’s behest, to four more areas in three types of facilities — hospice services in skilled nursing facilities (SNFs), nursing facilities (NFs), which are also known as nursing homes, and assisted living facilities (ALFs), says Kim Hrehor, project director for TMF Health Quality Institute, which generates PEPPERs for CMS. Three of the four new risk areas focus on routine home care, which accounts for 97% of hospice days billed, she says.

Medicare covers hospice care provided in hospitals, home health agencies, skilled nursing facilities and free-standing entities (RMC 3/12/12, p. 4). Patients waive their right to traditional inpatient services and receive palliative care instead, including pain management, nursing and dietary care and spiritual counseling. Once patients elect the hospice benefit, Medicare pays hospices a daily rate for every patient, even if minimal services are provided on a given day. Medicare also pays for some physician services separately.

Enforcers and auditors are cracking down on hospice services (RMC 5/13/13, p. 4). There have been a number of enforcement actions (RMC 1/12/15, p. 8; 11/4/13, p. 8). The new RAC, Connolly LLC, will be the first RAC dedicated to auditing hospice, home health and DME claims nationally, although it has to bide its time a bit longer because Performant, which lost the bid, filed a post-award protest with the Government Accountability Office, CMS said on Jan. 14.

data already exists on two hospice risk areas

On the PEPPER front, CMS asked TMF to expand its hospice data gathering and dissemination. TMF already generates data on two hospice risk areas and that will continue:

**Live discharge rate.** Even though the hospice benefit is for patients who are terminally ill, some are discharged alive after a relatively short time. Sometimes patients aren’t terminally ill anymore, or they may transfer to another hospice or another service area, or their behavior may be disruptive. If the volume of live discharges is very high, hospices should look at why. It’s possible very high rates of patients being discharged alive indicate they don’t meet hospice eligibility criteria or are dissatisfied with the quality of care, the Medicare Payment Advisory Commission said in its March 2012 report.

**Beneficiaries who receive hospice services for greater than 180 days.** Hospices that have a high percentage of beneficiaries with a long length of stay may want to ask themselves whether there’s a reason for the longer lengths of stay? Are the patients truly qualified for the hospice benefit, for example?

CMS has been increasingly concerned about hospice services in SNFs, NFs and ALFs in light of HHS Office of Inspector General findings, which were recently made public (RMC 1/19/15, p. 8). Medicare spent twice as much on hospice care in ALFs than it did five years ago, with hospice services lasting much longer — 98 days — than
they do in other settings even though patients in ALFs typically require less complex care. “Medicare paid an average of $156 per day for this care, amounting to $1,091 per week for a beneficiary receiving routine home care in an ALF. Most hospice visits were from aides. On average, of the 4.8 hours of visits per week to beneficiaries, 2.8 hours were for hospice aide services, 1.7 hours were for nursing services, and 0.3 hours were for medical social services. Nursing and medical social services are core hospice services,” OIG said.

So TMF added four risk areas to the PEPPER:

- **Continuous home care provided in an assisted living facility,**
- **Routine home care provided in an assisted living facility,**
- **Routine home care provided in a skilled nursing facility,** and
- **Routine home care provided in a nursing facility.**

The focus of the new risk areas obviously is routine and continuous care. Routine home care is the least expensive type of hospice care but accounts for the lion’s share of services, Hrehor says. Continuous home care comprises about 0.4% of hospice days of service, and is paid by per diem. The other two levels of hospice care are inpatient respite care and general inpatient care, which also account for tiny fractions.

One concern with hospice billing is that SNFs and ALFs already provide the kind of services, such as personal care (e.g., bathing) and light cleaning, that are built into Medicare payments for hospice, Hrehor says. That means hospice providers are paid for something they essentially get for free.

By adding four target areas, PEPPER will be available to a greater number of hospices, Hrehor says. The two original risk areas made PEPPER relevant to 3,000 of the nation’s 4,000 hospices. Now about 95% of them will be able to use the data for compliance monitoring, and the time is ripe with more audits coming.

Meanwhile, in another sign of the focus on hospices, CMS on Feb. 2 unveiled a program-integrity toolkit. And the agency is planning to reform the hospice payment system and adopt quality measures, as required by the Affordable Care Act.

**More PEPPER Data Is a Good Thing**

More PEPPER data is always a good thing, says Jane Sncinski, president of Post Acute Advisers in Atlanta. “Hospices should be doing a happy dance because the report will reflect information specific to that hospice, as seen by the eyes of CMS,” she says. “This data can direct their internal audits.” The deeper dive into hospice data may get health systems to pay more attention to this service line. Post-acute care is often neglected by health systems in their compliance reviews, Sncinski says. “When I ask what internal audits of post-acute care they have done as part of their compliance program, they say ‘we haven’t.’ They say ‘it is a small piece of our pie. We are an acute care provider,’” Sncinski says. “Then they start getting denials.” On the flip side, she says, hospices and other post-acute services should be striving for a low denial rate. A high denial rate poses a risk to the larger health systems as accountable care organizations are formed and as the industry transforms itself to take on more bundled payments. “You want to show you provide effective and cost effective care.” But so far, Sncinski doubts hospices have taken advantage of PEPPER data. It’s time, especially with the new data sets.