Hospices are the new focus of the Program for Evaluating Payment Patterns Electronic Report (PEPPER), a CMS compliance monitoring tool for hospitals and other providers. With hospices under greater scrutiny from Medicare watchdogs, PEPPER data will shine a light on potential problems in certain risk areas.

For the first time, PEPPERs will be sent this month to 2,700 of the nation’s 3,500 hospices, says Kim Hrehor, project director for TMF Health Quality Institute, which generates PEPPERs for CMS. “There is so much interest in the hospice PEPPER.”

PEPPERs are free reports on billing rates in certain risk areas. They are designed to help hospitals and other providers tailor their compliance monitoring to outliers unique to their facilities. PEPPERs were first provided to short-term acute care hospitals and later to long-term acute care hospitals, critical access hospitals, inpatient psychiatric facilities and inpatient rehab facilities. Now it’s the hospices’ turn, Hrehor tells RMC.

PEPPERs have different risk areas for each provider type, and there are two risk areas for hospices. Each hospice’s billing rates will be compared to other hospices in the state, Medicare administrative contractor (MAC) jurisdiction and nation in the two target areas, she says. It’s a red flag when a hospice’s billing in a target area is at or above the 80th percentile, which means it bills a higher percentage for that target area than do 80% of all hospices nationally. That doesn’t necessarily mean there was an error, but it’s up to the hospices to determine whether there’s a compliance issue or some reasonable explanation.

The two hospice risk areas are:

**Live discharge rate for beneficiaries with a length of stay less than 25 days:** 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.

“Unusually high rates of patients being discharged alive among some providers raises concerns that some hospices may be pursuing business models that seek patients likely to have long stays who may not meet the hospice eligibility criteria and then discharge them when they incur substantial cap liabilities,” the Medicare Payment Advisory Commission said in its March 2012 report. “It is also possible that in some cases unusually high live discharge rates could be an indicator of hospice patients’ dissatisfaction with the quality of care furnished by an individual hospice provider.” The first round of PEPPER cannot distinguish beneficiaries who are discharged by the hospice for a good reason from beneficiaries who discharge themselves, Hrehor says. “Hospices should keep this point in mind when reviewing their statistics for this target area,” she says.

There was no billing code until recently that let hospices explain why patients were discharged. However, effective July 1, 2012, CMS implemented new codes for this purpose (Change Request 7677), and that will allow PEPPER data in this risk area to be more refined in future reports. For example, hospices will use occurrence code 42 when the beneficiaries revoke the benefit; patient status code 50 or 51 when the beneficiary transfers hospices; no other indicator when the beneficiary is no longer ill; condition code H2 when the beneficiary is discharged for cause; and condition code 52 when the beneficiary moves out of the service area, according to MLN Matters 7677.

**Beneficiaries who receive hospice services for greater than 180 days.** According to Hrehor, hospices that have a high percentage of beneficiaries with a long length of stay may want to ask themselves, “Is there a particular reason that our beneficiaries tend to have longer lengths of stay? Is there something about our admissions process that we could improve to make sure we are truly admitting the patients who are qualified for the Medicare hospice benefit?”

Hrehor says that PEPPERs were developed as an educational tool for providers. But TMF shares the underlying statistics with MACs and RACs pursuant to its CMS contract. “I would hope that providers understand this is a way they can prepare for any area that MACs or RACs may be looking at in the future.”
Trinity Health, an integrity delivery system that owns hospices in five states, hasn’t put that much audit emphasis on hospices because its auditing and monitoring has determined that risk of noncompliance is low, says Andrei Costantino, director of organizational integrity. Hospices are audited on a rotating basis, along with other post-acute care services, and so far, so good, says Cathy Niland, a Trinity organizational integrity manager. “But PEPPER will help us better evaluate and manage our resources to focus on this risk area,” Costantino says.

Medicare covers hospice care provided in hospitals, home health agencies, skilled nursing facilities and freestanding entities (RMC 3/12/12, p. 4). Beneficiaries waive their right to traditional inpatient services and receive palliative care instead, including pain management, nursing and dietary care and spiritual counseling. Physicians must certify the patient is eligible for hospice care because of a terminal illness with a prognosis of no more than six months to live. The health reform law added a recertification requirement. Effective January 2011, the hospice medical director or nurse practitioner must have a face-to-face encounter with hospice patients after 180 days to recertify the need for more hospice care, and attest that the visit took place. The patient also must sign an election of hospice benefits. The hospice then writes a comprehensive plan of care to manage hospice services. It gets tricky because hospice patients may need hospital services that seem diagnostic and therapeutic but still serve the patient’s palliative needs. Hospice care can continue indefinitely if it is recertified by a physician or nurse practitioner, but there’s an annual per-beneficiary cap of around $25,000.

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