PEPPER Sessions Chapter 3 Target Areas Hospice

In this session, we're going to review the target areas in the hospice PEPPER, how they were identified, and what they could indicate for hospices. Hospices are reimbursed through the Medicare Hospice Benefit. And there is the risk for improper or inappropriate beneficiary enrollment in the Medicare Hospice Benefit. The Medicare Hospice Benefit has been identified as vulnerable to abuse. In 1999, the OIG, or the Office of Inspector General, encouraged hospices to develop and implement a compliance program to protect their operations from fraud and abuse. In addition, over the past few years, there have been several DOJ, or Department of Justice, investigations into fraud and abuse activities in hospices.

The hospice target areas, or the target areas in the Hospice PEPPER, were developed by a review of the Medicare Hospice Benefit, focusing on those areas that could be at risk for improper Medicare payments. We worked closely with CMS, subject matter experts to identify potentially vulnerable areas. We also analyzed national hospice claims data to identify areas which could be at risk, and which would be appropriate for addition to the PEPPER.

Over time, we've analyzed a number of areas in coordination with CMS. Our goal is to provide statistics in areas that could help identify a higher risk of improper Medicare payments, while understanding and taking into account the services that hospices provide. With that in mind, the target areas have changed, and they will probably continue to change over time, as we continue to assess those payment risks. I do want to stress that the PEPPER does not identify improper Medicare payments. Those can only be confirmed through a review of the documentation in the medical record to support the beneficiaries' admission to the Medicare Hospice Benefit.

I'd also like to mention another resource, which is the Comprehensive Error Rate Testing Report, the CERT Report. The 2019 Medicare Fee for Service Improper Payments Report, which is available on the CMS website, at CMS.HHS.gov/c-e-r-t, identified that there is an overall error rate 9.7% for hospices, which represents $1.8 billion in errors. The report does identify that hospital-based hospice services have a higher error rate of 18.9%, with $288 million in projected error. Freestanding hospices have an error rate of 8.9% with a projected $1.5 billion in error.

There are also a couple of Office of Inspector General, or OIG, reports that have been released in the past ten years pertaining to hospice services. And these have guided some target areas to be included in the Hospice PEPPER. The first one listed here is regarding hospice services provided in an assisted living facility. This report found that hospices provided care much longer and received much higher Medicare payments for beneficiaries in assisted living facilities than for beneficiaries in other settings of care. Hospice beneficiaries in assisted living facilities often had diagnoses that usually require less complex care. This report raised concerns about financial incentives created by the current payment system and the potential for hospices to target beneficiaries in assisted living facilities, because they may offer the greatest financial gain. And we do have four target areas in the PEPPER that are related to the recommendations in this report. Two of those are directly related to the services provided in an assisted living facility.

Another report from the OIG reviewed hospice general inpatient care stays, or GIP stays, and found that there were some concerns relating to the inappropriate use of GIP. GIP is intended to be short term, and may be provided in a hospice inpatient unit, in a hospital or in a skilled nursing facility, for pain control or acute chronic symptom management that cannot be addressed in other settings, for example the beneficiary's home. So, when a beneficiary has a long GIP stay, the concern is whether that GIP is appropriate and whether the beneficiary's symptoms are being effectively managed by the hospice. So we've added a new target area that is focused on long GIP stays.

What is a target area? In the PEPPER, we identify, a target area would represent claims or beneficiary episodes of service that have been identified as potentially prone to improper Medicare payments. We construct these target areas as ratios, where the numerator is a count of episodes, or claims, or days that are identified as potentially problematic. And the denominator is a larger reference group that also contains the numerator. So, let's review the target areas that are included in the Hospice PEPPER.

Here we have a listing of the target areas that are currently included in the Hospice PEPPER. We have three target areas that look at live discharges in several ways. We still have the long length of stay target area. The next target areas-- continuous home care provided in an ALF, we have the three target areas looking at routine home care in a number of settings-- those target areas were added a few years ago after an OIG study came out with some findings of financial incentives to provide care to beneficiaries who are residing in some of these different settings of care. So, we do have those target areas that monitor those concerns.

We also have a target area that looks at claims with a single diagnosis coded. CMS has always encouraged providers to not only include the terminal diagnosis on the claim, but any other concurrent diagnoses for which the beneficiary is receiving care. And I will say that the hospices have done a much better job over the past years, including all of those additional diagnoses when they are appropriate. We've got a target area that looks at episodes where there is no GIP or CHC provided, and then also long GIP days--stays

Let's review the target areas that are included in this Hospice PEPPER. Live discharges have been a concern, a focus of much attention over the past few years. The hospice benefit is designed to provide palliative and supportive care for terminally ill beneficiaries. And beneficiaries may be discharged alive from hospice care for several reasons, if they're determined to be no longer terminally ill, if they move out of the service area, if they're discharged for cause, or if they revoke the hospice benefit. Hospices that discharge alive a high proportion of beneficiaries might be admitting benes who do not meet the hospice eligibility criteria. It could also be an indication of quality of care concern, or that financial concerns are driving the hospice services. So, this is why we do have the three target areas actually that focus on live discharges. The first one listed on this slide is focused on those beneficiaries who are no longer terminally ill. Each of our target areas is structured with a numerator and a denominator. In this numerator, we are counting those beneficiary episodes that end during the fiscal year who are discharged alive, so the patient discharge status code is not equal to 40, 41, or 42. And we exclude the beneficiary transfers, we exclude the revocations, we exclude discharge for cause, and we also exclude moving out of the service area. These are beneficiaries who are discharged as no longer terminally ill. The denominator is a count of all of the beneficiary episodes discharged by death or alive by the hospice in that fiscal year.

The second target area that's focused on live discharges is specifically related to the revocations. Here, we're looking at the number of episodes where the beneficiary revoked the hospice benefit, and we were comparing those--that number to all beneficiary episodes. A beneficiary may choose to revoke the hospice care at any time, and they may re-elect to receive hospice coverage at a later time. The hospice cannot revoke the beneficiary's election, or request, or demand that the beneficiary revoke their election. CMS has identified concerns related to patterns of revocations in election of the Medicare Hospice Benefit for the purpose of potentially avoiding costly hospitalizations, expensive procedures, drugs or services. Patterns of discharge, hospital admission, and hospice re-admission do not provide a comprehensive, coordinated care experience for terminally ill patients. For that reason, we include this target area focused on the live discharges for beneficiary revocations.

The third target area for live discharges looks at live discharges that have a length of stay of 61 to 179 days. Beginning in fiscal year 2016, CMS implemented a higher Routine Home Care, or RHC, payment

rate for the first 60 days of care, after which the 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. So therefore, this target area is intended to help hospices monitor the percent of all beneficiaries discharged alive with a length of stay at 61 to 179 days. Hospices that have a high proportion of beneficiaries with a long length of stay may be admitting beneficiaries who do not meet the hospice eligibility criteria.

Before I move on, I want to make a comment about the live discharge statistic. Occasionally, we get questions from hospices who tell us that the live discharge rate in their PEPPER is not correct. When we investigate, we find that the hospice has used an incorrect code. Perhaps they've used the incorrect patient discharge status code, perhaps they're not using the codes to identify revocations, or transfers, or discharge for cause, or sometimes they've had changes in their billing claims filing, and so those codes are no longer being used. So, it's just a reminder that is important, when you're looking at your statistics in your PEPPER, if they don't seem correct, remember that we are calculating these statistics based on what is submitted to the MAC on the claim form. So, if something looks amiss, it's probably due to incorrect status codes, or condition codes, that are used on the claim. When you do identify that incorrect codes have been used, we encourage hospices to submit corrected claims to their MAC.

Long lengths of stay-- this target area calculates the proportion of beneficiaries treated during the year that had a length of stay of greater than 180 days. Hospices that have a high proportion of beneficiaries with long lengths of stay may be admitting beneficiaries who don't meet the hospice eligibility criteria. When admitted to the hospice benefit, the expectation is that the beneficiary has a six-month life expectancy. So, when hospice exceeds that length of stay for the majority of its beneficiaries, there is a concern related to the appropriateness of hospice care.

Now we're moving into those target areas that are related to the first OIG report that I mentioned. This target area, continuous home care provided in an assisted living facility, identifies the number of beneficiary episodes where the beneficiary was provided with at least eight hours of continuous home care while they resided in an assisted living facility. Continuous home care is billed on an hourly basis, as opposed to a per diem basis, as other hospice services. It is a costly level of care, although it does represent a very small percent, about 0.2% of all hospice days. There are not a lot of hospices that have reportable data for this target area, so don't be surprised if you do not see data for your hospice for this particular target area.

Routine home care provided in an assisted living facility-- now, the routine home care, that is the least costly service provided by hospices, but it does comprise the bulk of hospice care, about 99% of hospice days of service. So this target area measures the proportion of all routine home care days that were provided to beneficiaries residing in an assisted living facility.

We also measure the percentage of routine home care days that were provided to beneficiaries residing in a nursing facility or a nursing home, as well as the proportion of all routine home care days that were provided to the beneficiaries residing in a skilled nursing facility.

Now, again, we occasionally get questions from hospices about how we determine these statistics. When hospices submit claim for their services, there is a site of service code that identifies where the beneficiary was residing or was when they received those hospice services, called a Q Code. And so, we calculate the statistics based on the Q Codes that the hospice puts on their claims. There are a number of job aids, resources, that we have put on our website, on the hospice training and resources page, under Other Resources, at the bottom of the page. Again, that's PEPPERresources.org, hospice training and resources page, which give you more information about which Q Code to use and the appropriate use of those site-of-service codes.

We also have added within the past couple of years a couple of target areas. One is looking at claims with a single diagnosis coded. This is the number of claims ending in the report period that have only one diagnosis coded. Hospice claims should include the appropriate selection of principal diagnoses, as well as other additional and co-existing diagnoses related to the terminal illness, as well as any other condition. Coding guidelines specify that all of the patient's co-existing or additional diagnoses related to the terminal illness should be coded and reported on the hospice claim. The expectation is that hospices report all diagnoses, not just the terminal condition. So this provides accurate information regarding the hospice beneficiaries receiving services at the hospice.

The target area, No GIP or CHC, is also relatively new. Here we're looking at the number of beneficiary episodes that end in the report period where there is no GIP or CHC. This is to address the concern that beneficiaries may not have adequate access to the necessary level of care or that patient care may not always be driven by patient factors. The Medicare conditions of participation require hospices to demonstrate that they're able to provide---that they're able to provide--all four levels of care. That would be routine home care, general inpatient care, continuous home care, and inpatient respite care, in order to be a certified Medicare hospice provider.

In the fiscal year 2015, hospice final rules, CMS found that 77% of beneficiaries did not have any GIP, and 57% of hospices did not bill at least one day of CHC. CMS does recognize that there are appropriate circumstances where a hospice provides no GIP or CHC. But because of the concerns that we just talked about, we've added this as a target area to look at the percentage of episodes where the beneficiary does not receive any GIP or CHC.

And last, but not least, there is target area for the cost of PEPPER. And this was added in the Q4 FY16 release. And it is related to the second OIG study that I mentioned a little bit earlier. The OIG reviewed hospice GIP stays and found concerns relating to the inappropriate use of the GIP, and so we are looking at longer stays. The count of GIP stays with episodes ending in that report period or fiscal year, where there's a length of stay greater than five consecutive days. You may wonder how did we identify five days as the cut off? Well, in May 2013, there was an OIG study of GIP. And it found that one third of hospice GIP stays were longer than five days. Given that inpatient respite care, which is also intended to be short term, is limited to five days, with CMS's approval, we identify in the PEPPER long GIP stays as those that are greater than five consecutive days.