Live Discharges, The PEPPER, and the HIS- CMS Benchmarks

Annette Lee RN, MS, HCS-D, COS-C
Hospice Fundamentals

1

Today's Plan

- What PEPPER is and why its important in compliance and avoiding audits
- Risk areas identified in PEPPER
- Closer Look at Live Discharges data from PEPPER
- Suggestions for some measuring and monitoring ideas
- Actions of a Prudent Hospice™

How Does a Hospice Agency Avoid an Audit?

- Know the "Hot- Topics"- Who is looking at what and why?
  - MACs (Palmetto,NGS, CGS)
  - OIG
  - Supplemental Medical Review Contractor
  - MedPAC and OIG influence
- Know your own stats vs the benchmarks (PEPPER!)
- Know the payment rules, on which you would be audited against
  - Chapter 9 of the Medicare Benefit Policy Manual
  - MAC Local Coverage Determinations

Hospice has Some Targets

- GAO cites a large amount of claims are inappropriately paid
- MedPAC raises concerns about growth of hospice industry, increased live discharges and length of stay
- OIG had several scathing reports in last year regarding lacking standards of care and concerns about underutilization of the additional levels of care

Are You an Outlier?

- You want to be outstanding in your field for excellence and quality– but average in your data percentages
  - Industry association benchmarks
  - Your own agency benchmarks
  - Data warehouse benchmarks and peers

Palmetto: Non-Cancer /LOS TPE

- 2019 Palmetto announced they had selected over 400 hospices for TPE
- Also discussed potential edits based on CERT data:
  - Neuro diagnoses
  - GIP
  - Live discharges
  - NCLOS

PEPPER

Program for Evaluating Payment Patterns Electronic Report

HOSPICE FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

 7

PEPPER is Paused- Preparation is Not

CMS is taking measures to free up the attention of providers as they respond to the coronavirus (COVID-19) pandemic. To this end, the planned April 6, 2020, release of the Q4FY19 PEPPERs for CAHs, LTACHs, IPFs, IRFs, hospices, and SNFs has been delayed. As more information becomes available, the PEPPER Team will notify providers about the rescheduled release date for the Q4FY19 PEPPERs. Join our email list to receive updates regarding PEPPER distribution.

What is PEPPER and why should we care?

PEPPER =

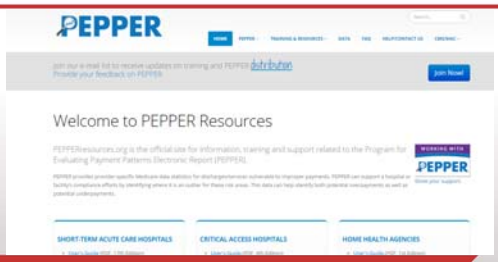
Program for
Evaluating
Payment
Patterns
Electronic
Report

It's a comparative data report prepared for individual health care providers with data drawn from three years' worth of claims information from the national Medicare claims database. It zeros in on specific target areas that have been determined to be *"at risk for improper Medicare payments." PEPPERs are intended to support a provider's compliance efforts by identifying where billing patterns are different from "the majority of other providers in the nation."*

How Do I Obtain my PEPPER?

- Obtaining requires the certification by the CEO, President, Administrator, Compliance Officer or Quality Assurance/Performance Improvement Officer
- PEPPER provides reports by state on retrieval rates
- https://pepper.cbrpepper.org/Training-Resources/Hospices

Obtain Your Report Yearly PEPPER https://pepper.cbrpepper.org/



An Underused Resource

Target Areas-No new additions this year

1. Live Discharges: No Longer Eligible
2. Live Discharges: Revocations
3. Live Discharges: LOS 61-179 Days
4. Long Length of Stay
5. Continuous Home Care in Assisted Facility
6. Routine Home Care in an Assisted Living Facility
7. Routine Home Care Provided in a Nursing Facility
8. Routine Home Care Provided in a SNF
9. Claims with a Single DX Code
10. Claims with No CHC or GIP
11. Long General Inpatient Care Stays

13

Live Discharges

- Includes all discharges, except expirations
- Must have at least 11 to be reportable
- CMS: "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 policy."

Live Discharges 61-179

- CMS: Hospice payments for RHC will decrease beginning on day 61. A high percentage of live discharges with a LOS 61-179 days could indicate that financial incentives are impacting patient care decisions.

Revocations

- CMS: 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.

Long Length of Stay

- Greater than 180 days
- CMS: This could indicate that beneficiaries are being enrolled in the Medicare Hospice Benefit who do not meet the hospice eligibility criteria.

Continuous Care in ALF

- CMS: 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

Routine Care in ALF

- CMS: 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.

Routine Care in SNF or NF

- CMS: This could indicate that beneficiaries who reside in an NF/SNF are being enrolled in the Medicare Hospice Benefit when they may not meet hospice eligibility criteria.
- It's all about the "outlier"
- Let's talk about definitions

SNF vs NF

- Q5004 is used for patients in a skilled nursing facility (SNF), or hospice patients in the SNF portion of a dually-certified nursing facility. The CR specifies 4 situations in which Q5004 should be reported.
- The beneficiary is receiving hospice care in a solely-certified SNF.
- The beneficiary is receiving general inpatient care in the SNF.
- The beneficiary is in a SNF receiving SNF care under the Medicare SNF benefit for a condition that is unrelated to the terminal illness, and is under routine home care.
- The beneficiary is receiving inpatient respite care in a SNF.
- If the beneficiary is in a nursing facility, but does not meet one of the four situations above, report the place of service as Q5003 (NF)

Claims with a Single Dx

- 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.

No GIP or CHC Provided

- This could indicate that the hospice is not providing the full spectrum of services as required by the Medicare program.

Long GIP Stay

- This could indicate that the hospice is initiating GIP services when not indicated/necessary.
- Seven days or more in one month (historically a MAC edit)

So, What's the Problem?

- Some of these topics don't indicate the hospice has done something "bad" – it just is an "outlier"

25

Percent vs Percentiles

- The Target Area Percent lets the provider know its billing patterns= How often you have X happen, or What percent of your patients care end in revocation? What percent of your patients live in an AL?
- The Percentiles give context by helping a provider understand how it compares to other providers- Where does your percent rank compared to your neighbors?

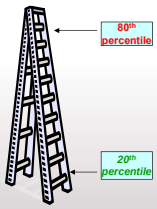
26

Percentiles- Where do We Land?

- To calculate Percentiles for all providers in a comparison group (nation, jurisdiction or state) the target area percents are sorted from largest to smallest for each time period.
- Example:
  - Hospice ABC has 15% of their patients living in ALs. If 40% of the providers' target area percent were lower than provider 15%, then provider ABC would be at the 40th percentile.

27

Percentile Calculation Example



- If a provider's percent is at or above the 80th percentile, it is considered an outlier.
  - 80% of providers had a lower percent.
- If a provider's percent is at or below the 20th percentile, it is considered an outlier (areas at risk for undercoding).
  - 20% of providers had a lower percent.

Live Discharges

Details of the Regulations
& Strategies for Managing

The Fundamental Difference?

Which party initiates the action

- The patient can revoke the benefit at any time and for any reason (RED DOORS)
- The hospice provider can discharge the patient only for limited reasons (GREY DOORS)

Regardless of the route, the end result is the same

- Beneficiary is no longer receiving services under the Hospice Medicare Benefit
- Full Medicare coverage for the terminal diagnosis is restored

PEPPER Data Door # 1

PEPPER Q4FY18
80th Percentile
National 14.1%

§418.28 Revoking Election of Hospice Care

Why	Revoking (reversing) the election of the hospice Medicare benefit
Initiated by	Patient or representative
How	Completing a written revocation
When	Anytime but effective date may not be earlier than date signed

Revocation: Important Points

1. Must complete the revocation statement in writing—no accommodation for a verbal revocation
2. Cannot backdate a revocation
3. No such thing as a "revocation by action"
4. A hospice may never "revoke a patient"
5. A hospice has a responsibility to counsel the beneficiary on the availability of revocation
6. The beneficiary does not have to provide a reason for revocation
7. Hospice documentation should include the circumstances around the revocation as best identified

Revocations

- Think of revocation as a service delivery failure
- Have an escalation process in place where leadership is notified immediately of any discussion of revocation
- Take any necessary steps
  - Understand the reason for the revocation
  - Attempt to correct any actual or perceived service issues
- Assign responsibility, as appropriate, to follow up for potential readmission
- Review at IDG meetings
  - What could have been done differently in this case
  - What was learned so the IDG can reduce revocations
  - Make sure you are meeting the needs of the patient and family through a patient driven interdisciplinary care planning process

Case

R.S. Admitted 4/28. Revoked 10/24. Lung cancer

- Wife was on service also and died 10/17
- Visits documented for pt were 10/16 RN and Chaplain, 10/23 SW
- 10/23 pt said wanted to sign off hospice and was too busy with daughter for visit at that time
- Revocation signed 10/24 with no note
- No visits made post wife deaths for 6 days. No nursing visit since 10/16 (day before wife's death)

PEPPER Data Door # 3

PEPPER Q4FY18
80th Percentile
National 14.2%

Discharge Medically Ineligible

Eligibility for the hospice Medicare benefit requires a life-expectancy of 6 months or less

- Certification by hospice physician and the for 1st benefit period, the patient's attending physician, if they have one

If the hospice determines that a beneficiary no longer meets that requirement they must discharge

38

Live Discharges

Infrastructure Needs

40

Policies and Procedures

- Clear, reliable, accessible
- Based on the regulations
  - Medicare
  - State
  - Medicaid
  - Accreditation standards

Have a goal to have 3 or less policies

- Discharge from hospice (wrapping in all types)
- Transfer to another hospice
- Revocation

41

Competencies & Knowledge

Front Line Staff	Live Discharge Categories When to Seek Guidance Documentation Points How to Have Conversations with Patients & Families Revocation Rules
Supervisors QAPI Compliance	The Regulations Documentation Points Why Topic Is Significant

42

Staff Competency

- Connection to assessments and care planning
- Accountability to standards
- IDG discussions after each leaving service areas- entering noncontracted facility, revocation, transfer in service area, for cause
  - DARE
  - What could we have done better/differently?

43

Auditing for Regulatory Compliance

- Beneficiary initiated
  - *Transfer to another Hospice*
  - *Revocation*
- Hospice Initiated
  - *Out of Service Area both to non-contracted facilities and geographically*
  - *"For cause" discharges*
  - *Medically Ineligible*

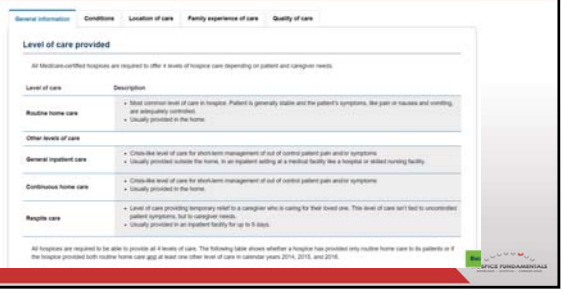
44

Hospice Compare

Does this Represent Your Agency's Care?

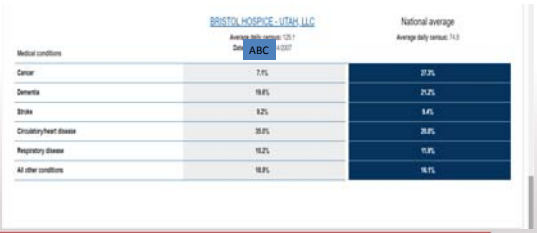
45

Hospice Compare– Educating the Public About Hospice

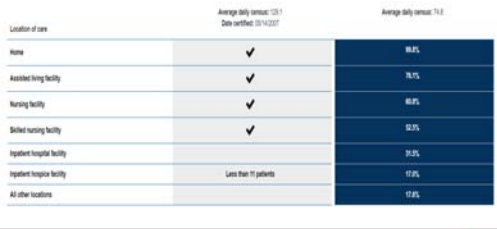


Ensuring Levels of Care

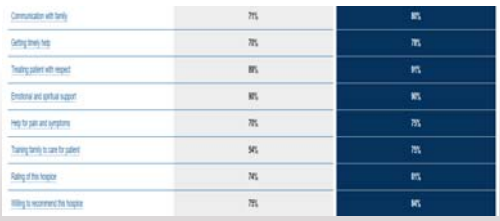
Notes Types of Conditions



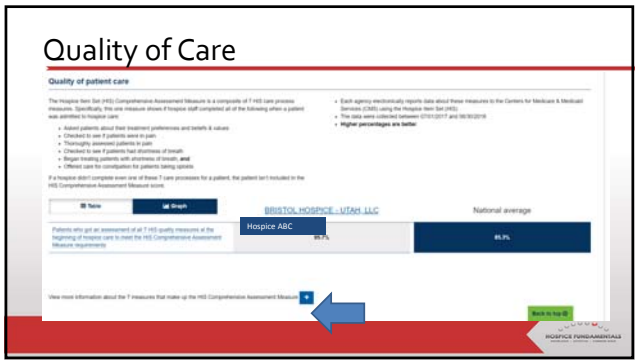
And Where Services are Provided



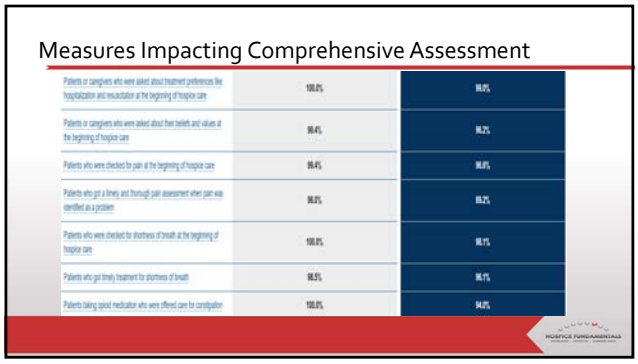
Family Caregiver Satisfaction



Quality of Care



Measures Impacting Comprehensive Assessment



Quality Measures from HIS

NQF	Measure Name
NQF #1641	Treatment Preferences
NQF #1647 -modified	Beliefs/Values Addressed (if desired by the patient)
NQF #1634	Pain Screening
NQF #1637	Pain Assessment
NQF #1639	Dyspnea Screening
NQF #1638	Dyspnea Treatment
NQF #1617	Patients Treated with an Opioid who are Given a Bowel Regimen

SECTION J –Health Conditions

Pain

J0900. Pain Screening

Enter Code ☐

A. Was the patient screened for pain?
0. **No** → Skip to J2030, Screening for Shortness of Breath
1. **Yes**

B. Date of first screening for pain:
☐☐ Month ☐☐ Day ☐☐☐☐ Year → Within two days

Enter Code ☐

C. The patient's pain severity was:
0. None → Skip to J2030, Screening for Shortness of Breath
1. Mild
2. Moderate
3. Severe
9. Pain not rated → Invalidates

Enter Code ☐

D. Type of standardized pain tool used:
1. Numeric
2. Verbal descriptor
3. Patient visual
4. Staff observation
9. No standardized tool used → Invalidates

HIS Quality Measures

Pain Screening (NQF #1634[1])

Measure Description	The percentage of hospice patients who were screened for pain during the initial nursing assessment.
Numerator	Patients are included in the numerator if they meet the following criteria during the numerator time window: 1. Patient was screened for pain (J0900A = 1), and 2. Patient reported that they had no pain (J0500C = 0) OR 3. Patient was screened for pain (J0900A = 1), and 4. Patient's pain severity was rated mild, moderate, or severe (J0900C = 1, 2, or 3), and 5. A standardized pain tool was used (J0900D = 1, 2, 3, or 4).
Numerator Time Window	Within 2 days of the admission date (J0900B - A0220 ≤ 2).
Denominator	Patients 18 years of age and older enrolled in hospice for 7 or more days.
Denominator Exclusions	Patients are excluded from the denominator if they are under 18 years of age and/or have a stay of less than 7 days in hospice.
HIS Items Used	J0900 – Pain Screening A0220 – Admission Date

[1] This measure is NQF-endorsed for use in the hospice and/or palliative care setting.

Comprehensive Pain Assessment

Pain

J0910. Comprehensive Pain Assessment

Enter Code ☐

A. Was a comprehensive pain assessment done?
0. **No** → Skip to J2030, Screening for Shortness of Breath
1. **Yes**

B. Date of comprehensive pain assessment:
☐☐ Month ☐☐ Day ☐☐☐☐ Year

C. Comprehensive pain assessment included:

Check all that apply
- ☐ 1. Location
- ☐ 2. Severity
- ☐ 3. Character
- ☐ 4. Duration
- ☐ 5. Frequency
- ☐ 6. What relieves/ worsens pain
- ☐ 7. Effect on function or quality of life
- ☐ 9. None of the above

HIS Quality Measures

Pain Assessment (NQF #1637)[1]	
Measure Description	The percentage of hospice patients who screened positive for pain and who received a comprehensive assessment of pain within 1 day of screening.[2]
Numerator	Patients are included in the numerator if they meet the following criteria during the numerator time window: 1. A comprehensive pain assessment was completed (J0910 = 1), and 2. The comprehensive pain assessment included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (5 or more of J0910C boxes checked).
Numerator Time Window	Within 1 day of the initial nursing assessment during which the patient screened positive for pain (J0910B - J0900B ≤ 1 day).
Denominator	Patients 18 years of age and older enrolled in hospice for 7 or more days and screened positive for pain during the initial nursing assessment (J0900C = 1, 2, or 3).
Denominator Exclusions	Patients are excluded from the denominator if they are under 18 years of age, have a stay of less than 7 days in hospice, and/or reported that they had no pain during the initial nursing assessment (J0900C = 0).
HIS Items Used	J0900 – Pain Screening J0910 – Comprehensive Pain Assessment

[1] This measure is NQF-endorsed for use in the hospice and/or palliative care setting.
[2] The pain screening took place during the initial nursing assessment.

57

Actions of a Prudent Hospice™

1. Download your PEPPER and review with special attention to red areas on the compare worksheet.
2. Review your data on Hospice Compare and CASPER
3. If you have an area of concern, take time to analyze and put additional actions into place as indicated.
4. Complete a Risk Table for your hospice
5. Think of revocations, discharge for entering noncontract hospitals and transfers within the service area as a service delivery failure and find and address systemic cause(s)

58

References/Resources

1. Pepper Training Resources https://pepper.cbrpepper.org/Training-Resources/Hospices
2. Medicare Hospice Regulations, Subpart B & C
3. Medicare Benefit Policy Manual, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance

59

Questions????

Contact Information:

Annette@hospicefundamentals.com

To Contact Us

Hospice Fundamentals
561-454-8121
heretohelp@hospicefundamentals.com

The information enclosed was current at the time it was presented. This presentation is intended to serve as a tool to assist providers and is not intended to grant rights or impose obligations.

Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.