Wage Index, PEPPER Data and Quality Reporting Updates

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5.13.22
Subscriber Webinar

Learning Goals:

1. Learners will be able to verbalize the changes proposed in payment for FY 2023
2. Learners will be able to discuss the updates on survey and medical review
3. Learners will identify the changes in the Hospice Quality Reporting Program

Hospice Payment Issues

Proposed for FY2023

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3

CMS Review of Hospice Utilization and Spending

- Length of stay- Avg=97days, Median=18 days
- Levels of care
- Live discharge rates
- SIA payments
- Spending outside of hospice during election
- Part A, Part B and Part D

A Look at Length of Stay: Dx and Location

Cancer: 53 days	COPD: 135 days	Neuro: 161 days
Home:90 days	NF: 133 days	ALF: 172 days

More Financial Angles

All hospice Medicare dollars in 2020 =$22.4B

Dollars spent on hospice for patients who had >180 days= $13.3 +

Dollars spent on hospice for patients who had <180 days= $9.2B

What Leads to Long Length in Stays?

- CMS: poor decisions on prognosis, financial incentives in payment, referrals
- Outcomes in long length of stay: Increased CMS spending, increased risk for agency, live discharges

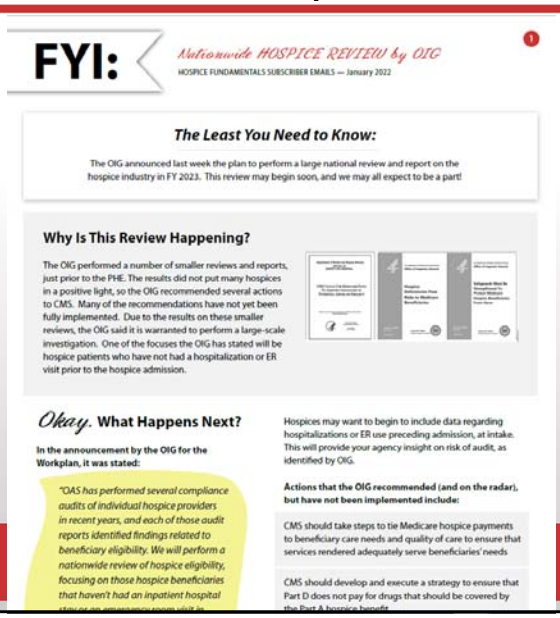
Live Discharges

- Long been tracked by CMS
- On PEPPER reports for agency benchmark
- 2020 live discharge rate: 15.4
  - 10% of hospices have 43% of live discharges!
- Raises concerns of abuse of benefit, quality of care, potential compliance concerns

MedPAC Report to Congress

- Audits: Long stays over 180 days, LOS in ALFs
- Investigate providers with LOS/Live DC rates and Over-Cap
- Review hospices who had high rates of payments from hospice days billed 1 year or more prior to death
- Physician education- impact of referral timing

OIG Announcement in January: Nationwide Audit



FYI: *Nationwide HOSPICE REVIEW by OIG*

HOSPICE FUNDAMENTALS SUBSCRIBER EMAILS — January 2022

The Least You Need to Know:

The OIG announced last week the plan to perform a large national review and report on the hospice industry in FY 2023. This review may begin soon, and we may all expect to be a part!

Why Is This Review Happening?

The OIG performed a number of smaller reviews and reports, just prior to the PHE. The results did not put many hospices in a positive light, so the OIG recommended several actions to CMS. Many of the recommendations have not yet been fully implemented. Due to the results on these smaller reviews, the OIG said it is warranted to perform a large-scale investigation. One of the focuses the OIG has stated will be hospice patients who have not had a hospitalization or ER visit prior to the hospice admission.

***Okay.* What Happens Next?**

In the announcement by the OIG for the Workplan, it was stated:

"OAS has performed several compliance audits of individual hospice providers in recent years, and each of those audit reports identified findings related to beneficiary eligibility. We will perform a nationwide review of hospice eligibility, focusing on those hospice beneficiaries that haven't had an inpatient hospital

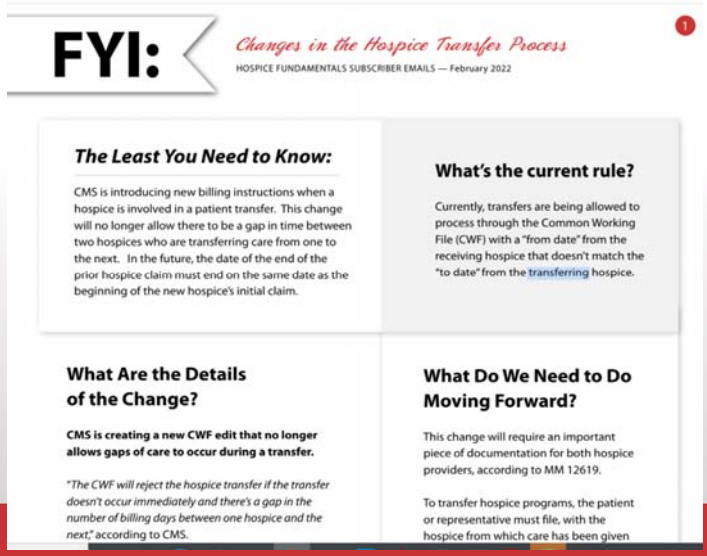
Hospices may want to begin to include data regarding hospitalizations or ER use preceding admission, at intake. This will provide your agency insight on risk of audit, as identified by OIG.

Actions that the OIG recommended (and on the radar), but have not been implemented include:

CMS should take steps to tie Medicare hospice payments to beneficiary care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs

CMS should develop and execute a strategy to ensure that Part D does not pay for drugs that should be covered by the Part A hospice benefit

CMS Announcement in February: Transfer Change



FYI: *Changes in the Hospice Transfer Process*

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The Least You Need to Know:

CMS is introducing new billing instructions when a hospice is involved in a patient transfer. This change will no longer allow there to be a gap in time between two hospices who are transferring care from one to the next. In the future, the date of the end of the prior hospice claim must end on the same date as the beginning of the new hospice's initial claim.

What's the current rule?

Currently, transfers are being allowed to process through the Common Working File (CWF) with a "from date" from the receiving hospice that doesn't match the "to date" from the transferring hospice.

What Are the Details of the Change?

CMS is creating a new CWF edit that no longer allows gaps of care to occur during a transfer.

"The CWF will reject the hospice transfer if the transfer doesn't occur immediately and there's a gap in the number of billing days between one hospice and the next," according to CMS.

What Do We Need to Do Moving Forward?

This change will require an important piece of documentation for both hospice providers, according to MM 12619.

To transfer hospice programs, the patient or representative must file, with the hospice from which care has been given

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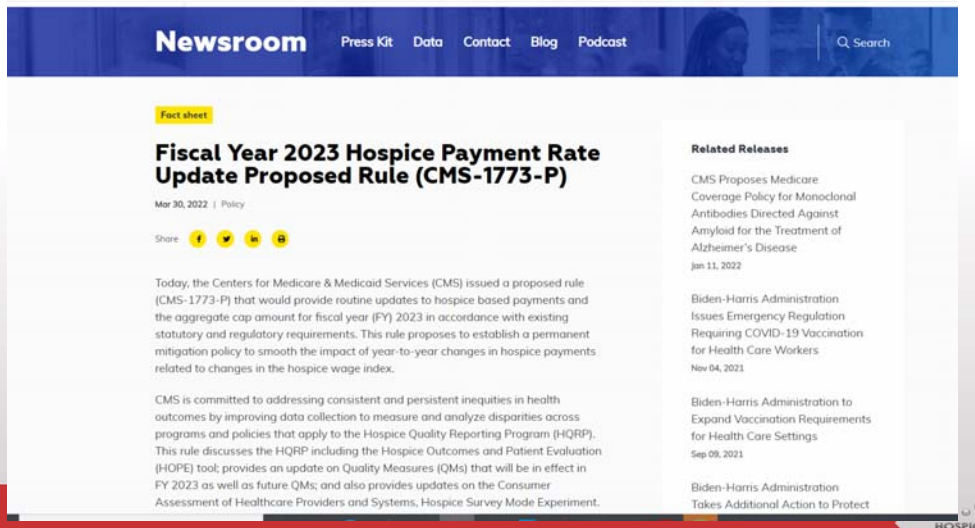
11

CMS Proposed Rule for Hospice in March



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Fact sheet

Fiscal Year 2023 Hospice Payment Rate Update Proposed Rule (CMS-1773-P)

Mar 30, 2022 | Policy

Share

Today, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule (CMS-1773-P) that would provide routine updates to hospice based payments and the aggregate cap amount for fiscal year (FY) 2023 in accordance with existing statutory and regulatory requirements. This rule proposes to establish a permanent mitigation policy to smooth the impact of year-to-year changes in hospice payments related to changes in the hospice wage index.

CMS is committed to addressing consistent and persistent inequities in health outcomes by improving data collection to measure and analyze disparities across programs and policies that apply to the Hospice Quality Reporting Program (HQRP). This rule discusses the HQRP including the Hospice Outcomes and Patient Evaluation (HOPE) tool; provides an update on Quality Measures (QMs) that will be in effect in FY 2023 as well as future QMs; and also provides updates on the Consumer Assessment of Healthcare Providers and Systems, Hospice Survey Mode Experiment.

Related Releases

CMS Proposes Medicare Coverage Policy for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease
Jan 11, 2022

Biden-Harris Administration Issues Emergency Regulation Requiring COVID-19 Vaccination for Health Care Workers
Nov 04, 2021

Biden-Harris Administration to Expand Vaccination Requirements for Health Care Settings
Sep 09, 2021

Biden-Harris Administration Takes Additional Action to Protect

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12

2023 Proposed Payment Increase

- Proposed FY2023 Payment Update Percentage: 2.7%
- Hospital market basket: 3.1%
- Less ACA productivity adjustment: 0.4 percentage point

Changes Proposed for Wage Index

- Wage index modifies for local rates due to variances in wages
- Hospice wage index= Hospital wage data
  - Care in home/NF/AL= wage index for residence
  - GIP or Respite= wage index for facility
- REMINDER: 2021 – revised OMB delineations impacting wage index values, based on Census
  - 5% cap was placed on wage index decreases to mitigate any major dips
- CMS proposed to make the 5% cap on decreases permanent for all readjustments going forward

	FY2022 Payment Rates	Adjustments	Proposed FY2023 Hospice Payment Update	Proposed FY2023 payment rates
Routine Home Care (days 1-60)	$203.40	*SIA budget neutrality factor *Wage index standardization factor *Labor share	X 1.027	$209.14
Routine Home Care (days 61+)	$160.74		X 1.027	$165.25

	FY2022 Payment Rates	Adjustments	Proposed FY2023 Hospice Payment Update	Proposed FY2023 Payment Rates
Continuous Home Care = 24 hours	$1,462.52 ($60.94 per hour)	*Wage Index Standardization Factor *Labor Share Standardization Factor	X 1.027	$1,505.61 ($62.73 per hour)
Inpatient Respite Care	$473.75		X 1.027	$486.88
General Inpatient Care	$1,068.28		X 1.027	$1098.88

FY2023 Proposed Payments

- FY2022 – failure to meet HQRP requirements during CY2020 results in 2% payment reduction over final rates this year
- Consolidated Appropriations Act of 2021 bumps HQRP reporting penalty to 4% beginning FY2024
- – REMEMBER: CY2022 reporting impacts FY2024 payments- So this truly begins THIS year!

APU Impact

Report Year	HIS	CAHPS	APU Year	APU%
• CY 2021	90%	Ongoing Monthly Participation	FY 2023	2%
• **CY 2022**	90%	Ongoing Monthly Participation	**FY 2024**	**4%**
• **CY 2023**	90%	Ongoing Monthly Participation	**FY 2025**	**4%**

Proposed Changes in Quality Measures

- NO NEW Measures!
- Current Measures for 2022:
  - Comprehensive Assessment completed (HIS composite)
  - HVLDL- May
  - HCI- May
  - CAHPS Hospice survey
    - CMS trying out web based mode for CAHPS
    - CMS testing a new shorter version

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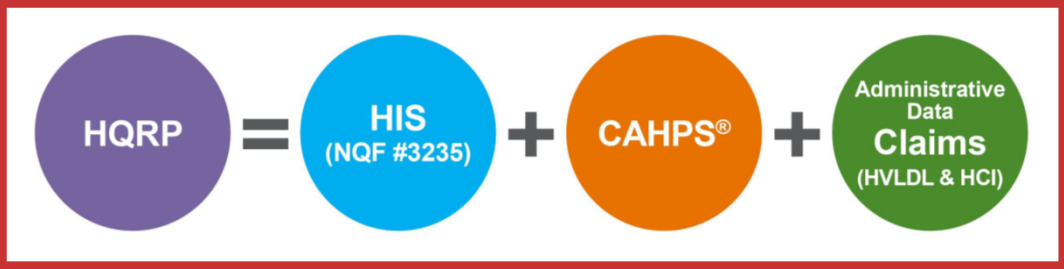
19



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QIES to iQIES

- Curent: QIES ASAP - Quality Improvement and Evaluation System – Assessment and the Submission Processing System
- FY2022: iQIES – internet Quality Improvement and Evaluation System
- Expected in 2022- time not yet defined
- HHAs migrated in 2020

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21

HIS Measures

- Proposed and finalized to remove the INDIVIDUAL measures from Care Compare "no earlier than May 2022"
- Patients Treated With An Opioid Who Are Given a Bowel Regimen
- Pain Screening
- Pain Assessment
- Dyspnea Screening
- Dyspnea Treatment
- Treatment Preferences
- Beliefs/Values Addressed (if desired by the patient)
- Maintaining Comprehensive Assessment at Admission

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22

CAHPS Five Star Rating

- Star new in 2022 (projected August)
- Ratings across 8 measures
- Minimum of 75 completed surveys
- Methodology
- Bell curve
- Future posting www.hospicecahpssurvey.org

Is there "HOPE"

- Proposed future rulemaking may include Hospice Outcomes and Patient Evaluation (HOPE) -based process measures intended to:
- Provide quality data through standardization of collection to evaluate the rate at which hospices use specific processes of care
- In "Beta testing" with agencies currently
- Determine hospices' compliance with practices that are expected to improve outcomes through survey and certification processes
- **May** see in Proposed Rule Making in Spring of 2023 for FY 2024

Hospice Visits in Last Days of Life
(HVLDL)

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Claims-Based Measures

- Hospice Visits Last Days of Life
- Hospice Care Index
- See FYI

FYI: *Hospice Care Index*

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The Least You Need to Know: CMS is planning on using claims-based data (for Medicare patients) to provide a new publicly displayed report card for hospices in 2022. This new composite measure will be called the Hospice Care Index (HCI) and consists of 10 claims-based measures.

More Info

The hospice quality reporting program, which began in 2014, has continued to evolve over the last seven years. Currently, both the Hospice Item Set (HIS) and the Hospice CAHPS are used to reflect the quality of the hospice care. Moving forward, CMS will have a more holistic approach that captures the hospice practices throughout care.

Future HORP: Integrating HOPE and Administrative Data (claims)

Administrative Data
(e.g. claims)

+

Further Details

These are the 10 areas that CMS is currently collecting data on for the claims-based Hospice Care Index:

HCI FY2022 Hospice Proposed Rule
1. CHC or GIP Provided
2. Gaps in Nursing Visits
3. Early Live Discharges
4. Late Live Discharges
5./6. Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission (Burdensome

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26

Hospice Visits Last Days of Life

- "HVLDL" Measure finalized
- Proportion of patients who received visits from a **RN** or a **medical social worker** (non-telephonically) on **at least two of the last three days of life**
- Re-specified Hospice Visits When Death is Imminent (HVWDII)
- Claims-based (Only will include Medicare)

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27

HVLDL

- Will publicly report no earlier than May 2022
- Utilizing 8 quarters of data, excluding Q1/Q2 2020 claims

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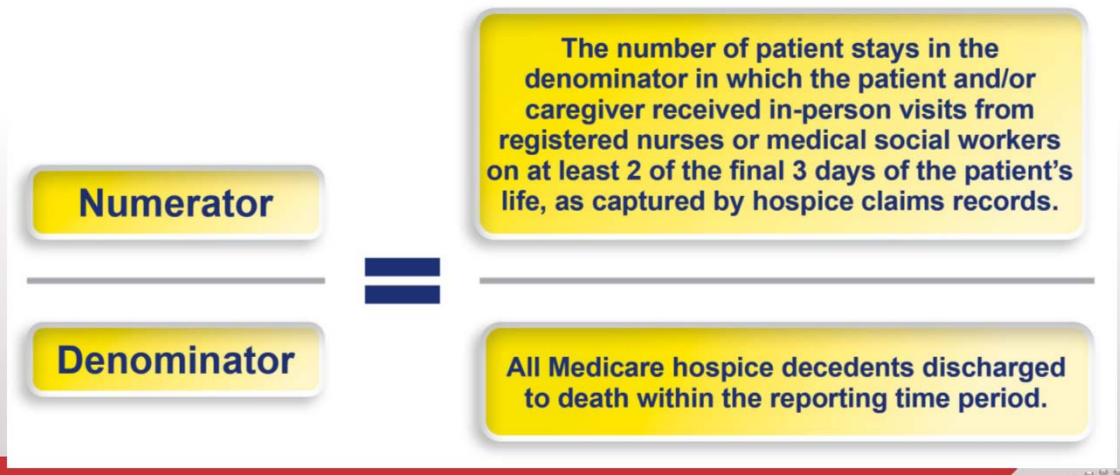
28

Calculation of HVLDL



Exclusions to HVLDL

- Same exclusions as HVWDII: Patient did not die under hospice care as indicated by reason for discharge.
- Patient received any continuous home care, respite care, or general inpatient care in the final three days of life.
- Patient was enrolled in hospice less than three days. HVLDL looks at visits in the last three days of life; patients must receive hospice services for **at least three days** to be included in the measure

Hospice Care Index (HCI)

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Finalized: Hospice Care Index Measure

- Capture multiple aspects of hospice care with a broad, holistic set of claims-based quality measures
- Multiple indicators
- Threshold for each indicator will be developed using industry percentiles
- Overall score is calculated on the number of instances when the hospice met a set threshold (one point out of 10 possible)
- Public reporting May 2022
- Utilizing up to 8 quarters of claims- but excluding Q1/Q2 2020
- Final HCI score only

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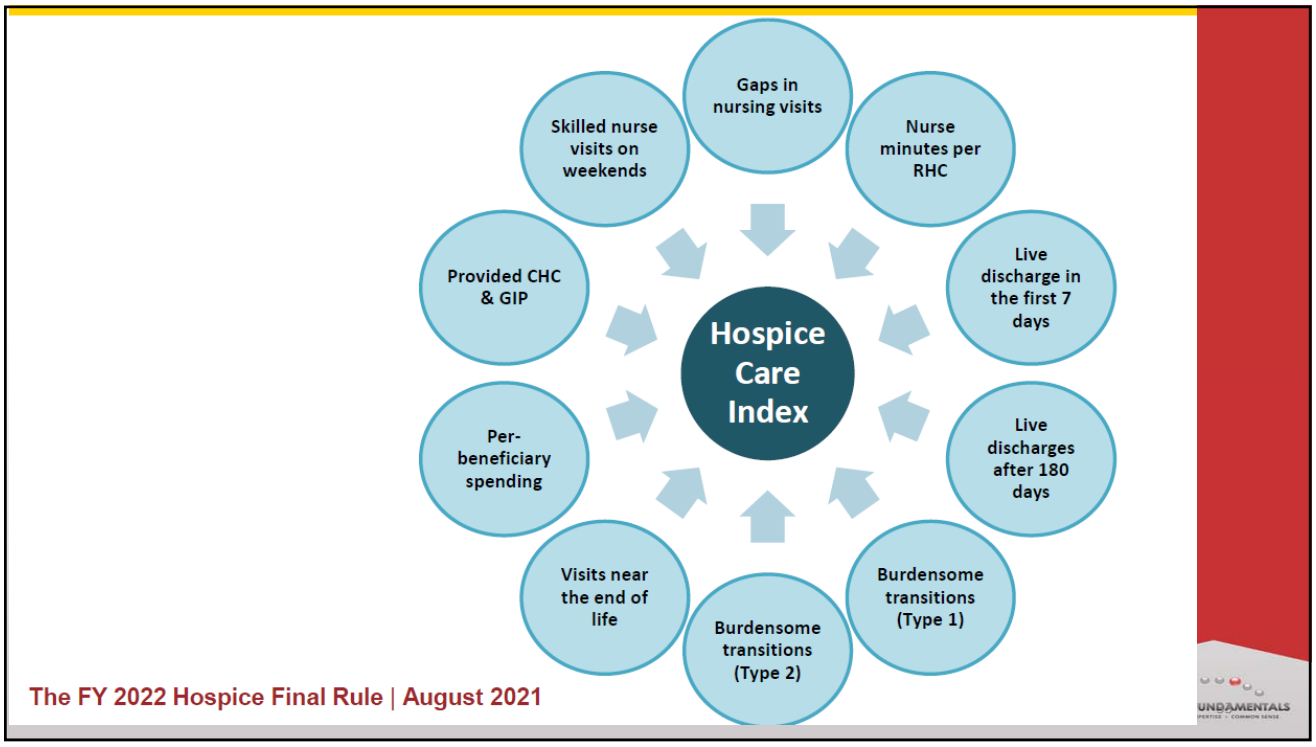
32



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Hospice Care Index Indicator Scoring

Indicators (Hospice Score Units)	Index Earned Point Criteria	Points Earned?	Points Awarded
Provided CHC/GIP (% days)	Hospice Score Above 0%	Yes	+1
Gaps in skilled nursing visits (% elections)	Below 90 Percentile Rank	No	0
Early live discharges (% live discharges)	Below 90 Percentile Rank	Yes	+1
Late live discharges (% live discharges)	Below 90 Percentile Rank	Yes	+1
Burdensome transitions, Type 1 (% live discharges)	Below 90 Percentile Rank	Yes	+1
Burdensome transitions, Type 2 (% live discharges)	Below 90 Percentile Rank	Yes	+1
Per-beneficiary Medicare spending (U.S. dollars, $)	Below 90 Percentile Rank	Yes	+1
Skilled nursing care minutes per RHC day (minutes)	Above 10 Percentile Rank	No	0
Skilled nursing minutes on weekends (% minutes)	Above 10 Percentile Rank	Yes	+1
Visits near death (% decedents)	Above 10 Percentile Rank	Yes	+1
		HCI Total Score =	8

The FY 2022 Hospice Final Rule | August 2021 42

PEPPER Updates

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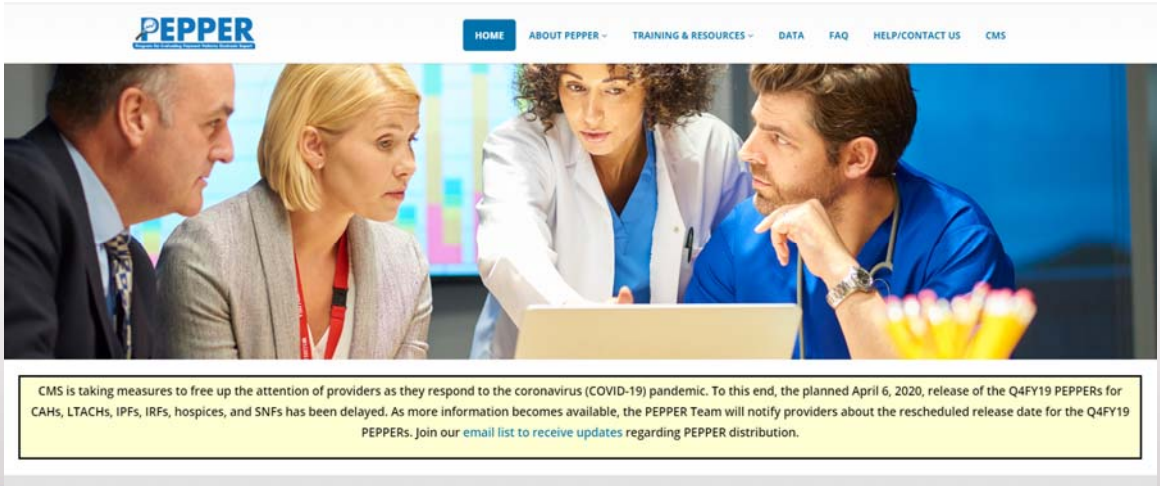
35

PEPPER is Back On Schedule!



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36

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.

This is provided by a contractor for the Program Integrity

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."*

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37

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

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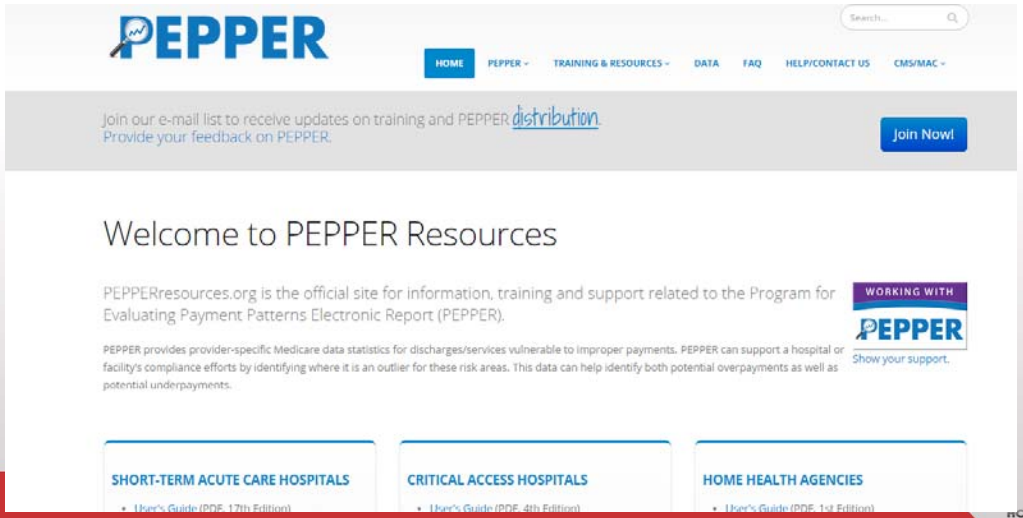
38

Obtain Your Report Yearly PEPPER

https://pepper.cbrpepper.org/



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39

Target Areas-

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
12. Average Part D Claims Paid During Hospice Benefit

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40

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?

41

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 ALFs. If 40% of the providers' target area percent were lower than provider's 15%, then provider ABC would be at the 40th percentile.

42

Compare Report Example (Tab)

The Compare Targets Report displays statistics for target areas that have reportable data (11+ target discharges) in the most recent time period. Percentiles indicate how a hospice's target area percent compares to the target percents for all hospices in the respective comparison group. For example, if a hospice's jurisdiction (see below) is 80.0, 80% of the hospices in the Medicare Administrative Contractor (MAC) comparison group have a lower percent value than that hospice. The hospice's state percentile (if displayed) and the hospice national percentile values should be interpreted in the same manner. Percentiles at or above the 80th percentile for any target areas or at or below the 20th percentile for coding-focused target areas indicate that the hospice may be at a higher risk for improper Medicare payments (outlier status). The greater the percent value, particularly the national and/or jurisdiction percentile, the greater the consideration should be given to t[illegible]target area

Table 2 Compare Targets Report

Target	Number of Target Dischs	Percent (You)	Hospice National %ile	Hospice Jurisdict. %ile (MAC)	Hospice State %ile	Sum of Payments
Live Discharges Revocations	54	19.3%	83.8	68.8	88.9	$1,123,681
Live Discharges LOS 61-179	30	38.0%	76.1	67.5	73.4	$533,610
Long LOS	65	23.2%	74.4	67.1	60.6	$3,390,600
Routine Home Care in Assisted Living Facility	21,345	44.3%	86.8	79.1	68.0	Not Calculated
Routine Home Care in Nursing Facility	251	0.5%	0.4	0.4	2.8	Not Calculated
Claims w/ Single Diagnosis Coded	123	6.5%	34.3	24.3	46.3	Not Calculated
No GIP or CHC	263	93.9%	42.7	41.8	28.2	$5,169,216

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43

Live Discharges- Revocations

- *N:* 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
- *D:* 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)

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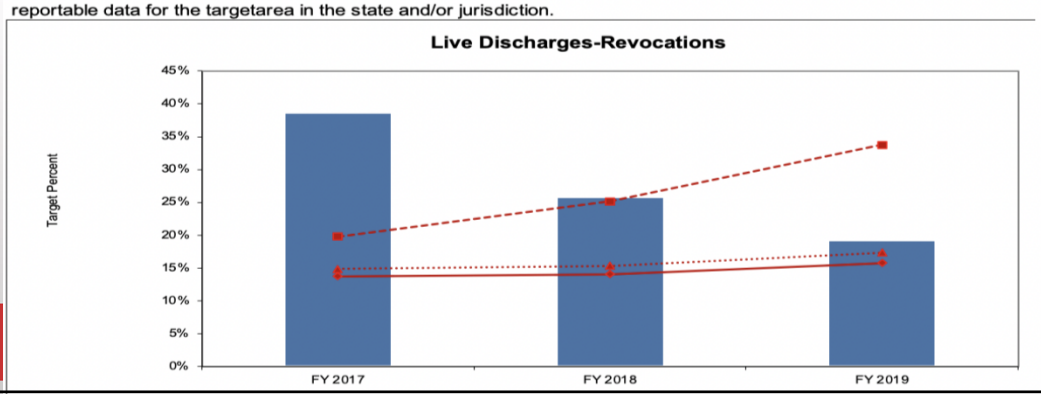
44

YOUR HOSPICE	FY 2017	FY 2018	FY 2019
Outlier Status	High Outlier	High Outlier	High Outlier
Target Area Percent	38.7%	25.9%	19.3%
Target Count	41	56	54
Denominator Count	106	216	280
Target (Numerator) Average Length of Stay	56.2	127.6	124.3
Denominator Average Length of Stay	46.0	85.7	118.8
Target (Numerator) Average Payment	$9,943	$20,590	$20,809
Target (Numerator) Sum of Payments	$407,648	$1,153,041	$1,123,681

Table 6 Comparative Data for Live Discharges-Revocations

COMPARATIVE DATA	FY 2017	FY 2018	FY 2019
National 80th Percentile	13.8%	14.1%	15.8%
Jurisdiction 80th Percentile	19.8%	25.2%	33.8%
State 80th Percentile	14.9%	15.3%	17.4%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the targetarea in the state and/or jurisdiction.



45

Live Discharges: No Longer Terminally Ill

- *Numerator (N):* 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:
- • 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)

- *Denominator (D):* 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)

46

Live Discharges 61-179

- *N:* 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 length of stay (LOS) of 61 – 179 days
- *D:* 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)

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47

Long Length of Stay

- *N:* 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)
- *D:* 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)

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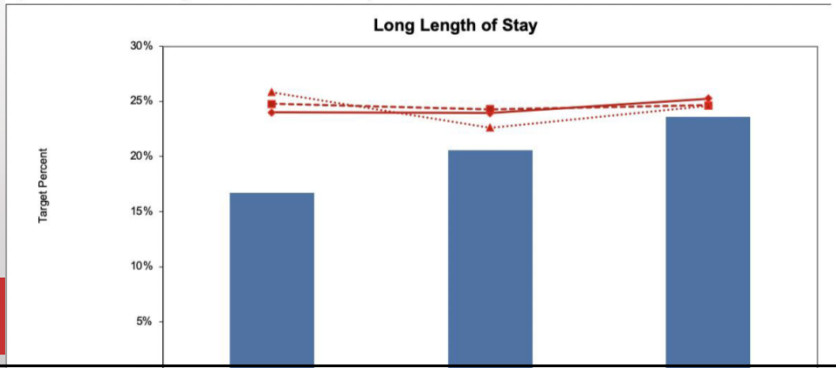
48

YOUR HOSPICE	FY 2017	FY 2018	FY 2019
Outlier Status	Not an outlier	Not an outlier	Not an outlier
Target Area Percent	16.8%	20.7%	23.7%
Target Count	56	66	66
Denominator Count	333	319	278
Target (Numerator) Average Length of Stay	370.0	456.7	506.6
Denominator Average Length of Stay	95.9	125.0	150.8
Target (Numerator) Average Payment	$48,226	$59,221	$65,760
Target (Numerator) Sum of Payments	$2,700,646	$3,908,603	$4,340,175

Table 10 Comparative Data for Long Length of Stay

COMPARATIVE DATA	FY 2017	FY 2018	FY 2019
National 80th Percentile	24.0%	23.9%	25.3%
Jurisdiction 80th Percentile	24.8%	24.3%	24.6%
State 80th Percentile	25.8%	22.6%	24.6%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.



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49

Routine Care in ALF/NF/SNF

- Three separate measures
- *N:* count of Routine Home Care (RHC) days (revenue code = 0651) provided on claims ending in the report period that indicate the beneficiary resided in a/an____ ALF/NF/SNF (Q5002/5003/5004)
- *D:* count of all RHC days (revenue code = 0651) provided by the hospice on claims ending in the report period

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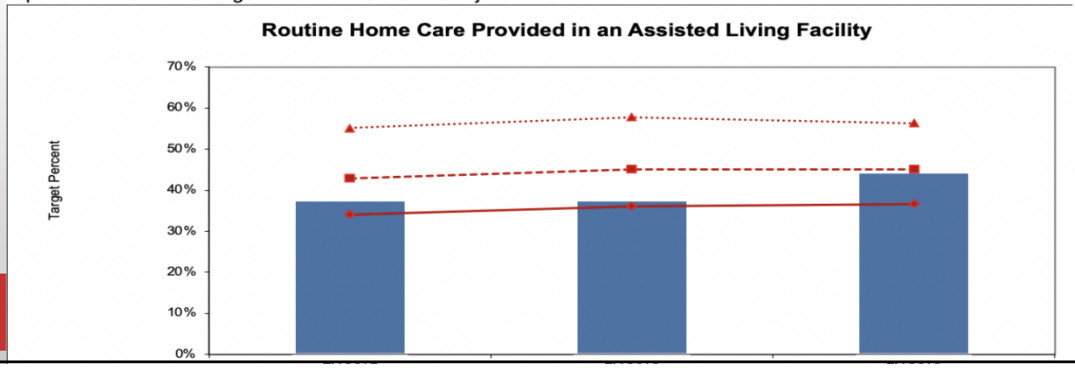
50

YOUR HOSPICE	FY 2017	FY 2018	FY 2019
Outlier Status	High Outlier	High Outlier	High Outlier
Target Area Percent	37.6%	37.6%	44.3%
Target Count	4,268	10,939	21,345
Denominator Count	11,339	29,092	48,140
Target (Numerator) Average Length of Stay	No data	No data	No data
Denominator Average Length of Stay	No data	No data	No data
Target (Numerator) Average Payment	No data	No data	No data
Target (Numerator) Sum of Payments	No data	No data	No data

Table 14 Comparative Data for Routine Home Care Provided in Assisted Living Facilities

COMPARATIVE DATA	FY 2017	FY 2018	FY 2019
National 80th Percentile	34.1%	36.1%	36.6%
Jurisdiction 80th Percentile	42.9%	45.1%	45.1%
State 80th Percentile	55.1%	57.8%	56.3%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.



51

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 beneficiary is receiving hospice care in a solely-certified 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 general inpatient care in the SNF.
  - 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)

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52

Average Part D Claims per Beneficiary

- New Target Area Report as of the FY2020 PEPPER Report
- Numerator: Count of Medicare Part D claims for beneficiaries billed during hospice episodes of **at least 3 days, beginning one day after admission and ending one day before discharge for beneficiaries discharged alive**
- Denominator: Count of all beneficiary episodes discharged (by death or alive, and at least 3 days in length), by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)

- **WHY?** In August 2019, the OIG estimated that Medicare Part D spent $160.8M for drugs that should have been paid for by hospice organizations

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53

YOUR HOSPICE	FY 2018	FY 2019	FY 2020
Outlier Status	Not an outlier	Not an outlier	Not an outlier
Target Area Rate	4.71	4.49	6.16
Target Count	961	1,211	1,966
Denominator Count	204	270	319
Target (Numerator) Average Length of Stay	126.1	163.2	217.0
Denominator Average Length of Stay	90.6	123.3	147.2
Target (Numerator) Average Payment	Not Calculated	Not Calculated	Not Calculated
Target (Numerator) Sum of Payments	Not Calculated	Not Calculated	Not Calculated

No data: Target or Denominator count is less than 11 and is suppressed due to confidentiality requirements.
Table 26 Comparative Data for Average Part D Claims

COMPARATIVE DATA	FY 2018	FY 2019	FY 2020
National 80th Percentile	10.88	11.54	12.10
Jurisdiction 80th Percentile	10.16	11.22	11.41
State 80th Percentile	8.71	8.89	8.67

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

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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.

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55

No GIP or CHC Provided

- *N:* 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)
- *D:* 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)

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

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56

Long GIP Stay

- *N:* count of General Inpatient Care (GIP) stays within episodes ending in the report period with a length greater than five consecutive days
- *D:* count of all GIP stays within episodes ending in the report period, identified as 1+ consecutive days of revenue code 0656

- This could indicate that the hospice is initiating GIP services when not indicated/necessary.

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57

So, What's the Problem?

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

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58

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
  - What could we have done better/differently?

59

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*

60

Actions of a Prudent Hospice™

1. Download your PEPPER and review with special attention to red areas on the compare worksheet.
2. If you have an area of concern, take time to analyze and put additional actions into place as indicated.
3. Complete a Risk Table for your hospice
4. 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)

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61

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

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62

Thank you!

Questions????

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63

Objectives

	At the conclusion of this session, learners will be able to:
Identify	Identify the rules used for hospice surveys
Discuss	Discuss the survey process, including what should be included in a self assessment
Develop	Develop a Survey Readiness Binder, based on the tools provided

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Questions????

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THANK YOU!

Questions?

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To Contact Us

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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.

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67